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Maryland

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JULY, 1961



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OCEAN CITY (SEMIANNUAL) MEETING—FRIDAY, SEPTEMBER 15, 1961
COMMANDER HOTEL, OCEAN CITY, MARYLAND



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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

MARYLAND

STATE MEDICAL JOURNAL

Volume 10 July 1961 Number 7

A.M.E.F. CHECKS PRESENTED AT PRESIDENTIAL DINNER

Maryland's two medical schools received \$23,583.94 from the American Medical Education Foundation in 1960. Of this sum, \$12,045.38 went to the University of Maryland School of Medicine and \$11,538.56 went to The Johns Hopkins University School of Medicine.

The grants were awarded at the presidential dinner on April 27. Whitmer B. Firor, M.D., as one of his last official acts as president of the Medical and Chirurgical Faculty, presented the checks to Thomas B. Turner, M.D., dean of The Johns Hopkins University School of Medicine, and William S. Stone, M.D., dean of the University of Maryland School of Medicine.

The money may be used at the discretion of the deans of the schools. Dr. Turner disclosed that the Johns Hopkins grant will be used for loan funds for medical students. Dr. Stone said the funds received by the University of Maryland will be used to purchase research and teaching equipment and to provide some salaries for additional part time faculty.

The American Medical Education Foundation was established in 1951 by the American Medical Association to encourage physicians to give greater financial support to medical schools. Physicians may designate their contributions for a specific school. All money not designated is divided equally among eighty-five medical schools across the United States.

Whitmer B. Firor, M.D.

William S. Stone, M.D.

Thomas B. Turner, M.D.



YOUR
MEDICAL
FACULTY
AT WORK

John Sargeant
Executive Secretary



Dr. Fort

Dr. Goldstein

Council, April 26 and 28, 1961

1. Authorized legal defense for various members who had requested it.
2. Authorized employment of a librarian to replace Miss Louise D. C. King, who retired on June 1 from this post.
3. Heard expression of appreciation from the retiring chairman.
4. Heard expression of appreciation from Wetherbee Fort, M.D., retiring treasurer, for the honor paid him at the Council meeting on March 21.
5. Elected Everett S. Diggs, M.D., chairman of the Council and M. McKendree Boyer, M.D., vice chairman.
6. Welcomed new members of the Council.
7. Approved subscription to the Shearon Legislative Service for one year.

House of Delegates, April 26, 1961

1. Had formally presented a rewritten set of Bylaws for the Faculty.
2. Discussed and made amendments to the Bylaws presented.
3. Heard the treasurer's report for the period January 1, 1956, through April 28, 1961, as well as a summary of the progress made by the Faculty during this time.
4. Presented an illuminated scroll to Dr. Fort, retiring treasurer, from the members.
5. Heard the report, illustrated with colored slides, of the Building Committee chairman on the building renovation program.
6. Presented to Dr. Goldstein an illuminated scroll and a plaque for hanging in the building, for his work on the Building Committee.

7. Heard the report of the Nominating Committee.

House of Delegates, April 28, 1961

1. Concluded action on the report of the Bylaws Committee, adopting the report with its amendments and referral of some sections for further study.

2. Conducted the annual election of Faculty officers, who will assume office at the close of the 1962 Annual Meeting.

3. Elected Melvin B. Davis, M.D., Baltimore County, to the Council to fill the term of Charles F. O'Donnell, M.D., who became president-elect.

4. Adopted committee reports essentially as presented by the various committees. Copies of these reports are available to all Faculty members through the Faculty office.

5. Adopted a resolution providing for cessation of Blue Shield payments to hospital educational funds, with the understanding that Blue Shield should pay only (1) participating physicians under Blue Shield (non-house officers) or (2) the subscriber, when the service is rendered by a non-participating physician (non-house officer).

6. Rejected the following resolutions which had been introduced for consideration:

- A. Urging physicians not to display identification tags on their cars.**
- B. Requesting inclusion of physicians under Social Security.**
- C. Urging establishment of policy that fee schedules negotiated provide for fees based on the service rendered and not on who rendered the service.**

NEW OFFICERS ELECTED

To assume office at conclusion of 1962 Annual Meeting.

President

CHARLES F. O'DONNELL, Towson

Vice Presidents

JOHN G. BALL, Bethesda
WETHERBEE FORT, Baltimore
C. RODNEY LAYTON, Centreville

Secretary

WILLIAM CARL EBELING, Baltimore

Treasurer

HOWARD B. MAYS, Baltimore

Councilors

AMOS R. KOONTZ, Baltimore, Central District (1965)
WILLIAM A. PILLSBURY, Timonium, Central District (1965)
J. EMMETT QUEEN, Baltimore, Central District (1965)
THURSTON HARRISON, Easton, Eastern District (1965)
ARTHUR O. WOODY, La Plata, Southern District (1965)

Delegate to American Medical Association

J. SHELTON EASTLAND, Baltimore (Jan. 1962-Dec. 1964)

Alternate Delegate to American Medical Association

WILLIAM B. HAGAN, Mt. Rainier (Jan. 1962-Dec. 1964)

Committee on Scientific Work and Arrangements

J. MORRIS REESE, Lutherville (1966)

Library Committee

A. AUSTIN PEARRE, Frederick (1967)

Finney Fund Committee

RICHARD G. COBLENTZ, Baltimore (1967)

Board of Medical Examiners

VERNON H. NORWOOD, Baltimore (June 1961-June 1965)
C. STANFORD HAMILTON, Pocomoke City (June 1961-June 1965)

Your Invitation
to the

OCEAN CITY MEETING

(Semiannual Meeting)

MEDICAL AND CHIRURGICAL FACULTY

FRIDAY, SEPTEMBER 15, 1961

HEADQUARTERS — COMMANDER HOTEL

OCEAN CITY MARYLAND

ENJOY THE SCIENTIFIC AND BUSINESS SESSIONS
HAVE FUN — RELAX IN THE SUN

BUSINESS SESSIONS

Council—Thursday, September 14, 8:00 p.m.
House of Delegates—Friday, September 15, 9:30 a.m.

FRIDAY, SEPTEMBER 15



SCIENTIFIC SESSION

12:30 p.m.

COMMANDER JOHN H. EBERSOLE, M.C., U. S. Naval Medical Center, Bethesda, will speak on his experiences on the atomic submarines, The Nautilus and The Sea Wolf.

LUNCHEON

Choice of

Clam Bake on the Beach—2:00 to 3:00 p.m.

OR

Smorgasbord in the Dining Room—1:30 to 3:30 p.m.

DANCE

Dining Room—9:30 p.m. to 1:00 a.m.

This program of interest and enjoyment has been planned by the Committee on Program and Arrangements, Houston S. Everett, M.D., Chairman.

(continued on next page)

OCEAN CITY MEETING PROGRAM (continued)

PLAN NOW

MAKE IT A WEEKEND WITH YOUR FAMILY AND FRIENDS

FRIDAY, SEPTEMBER 15, 1961

OCEAN CITY, MARYLAND

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CHRONIC RECURRING SPONTANEOUS PNEUMOTHORACES ASSOCIATED WITH MENSTRUATION

Report of a patient manifesting recurring spontaneous pneumothoraces associated with the onset of her menstrual cycle. No demonstrable disease was found in the lung, pleural cavity, or diaphragm. After surgery her symptoms disappeared.

Robert C. Wingfield, M.D.

ON DECEMBER 13, 1958, E. R. Maurer, J. A. Schaal, and L. F. Mendez, of Cincinnati, Ohio, reported a case of right sided spontaneous recurring pneumothorax in a thirty-five year old woman during menstruation (1). Altogether, their patient had approximately fourteen spontaneous pneumothoraces, all occurring in the right hemithorax and during menstruation. This patient was subjected to right thoracotomy. An endometrial implant about 4 by 3 centimeters was discovered on the central portion of the diaphragm and was excised, after which the patient was free of symptoms. Microscopic examination of the excised tissue revealed endometrial stroma and glands extending throughout the fibromuscular structure of the diaphragm.

This case is the first recorded instance of successful surgical treatment of chronic recurring pneumothorax due to aberrant endometrial tissue implants. Instances have been recorded of endometrial implants in lung parenchyma (2), but no recorded cases of spontaneous lung collapse caused by this aberrant tissue growth in lung or adjoining structures have been discovered.

Castration, uterine pregnancy, and administration of estrogens and androgens will relieve symptoms and prevent growth of tissue implants in endometriosis. No mention was made of estrogenic therapy in this patient prior to surgery; however, after her recovery from the thoracotomy, a total hysterectomy with bilateral salpingo-oophorectomy was performed, because this patient also had concomitant pelvic endometriosis (1).

The following report is similar to that of the previously mentioned patient in many respects.

HISTORY: The patient, a white widow, age 33, was first seen on July 29, 1957. Her chief complaint was a sudden, sharp, severe pain in the right chest, below the tip of the scapula, with associated dyspnea. She stated that since 1952, after the birth of her last child, she had experienced approximately forty or forty-five bouts of severe chest pain and shortness of breath. On each occasion she noted the onset of menstruation. The chest pain would be fairly severe for two days and gradually subside. On occasions, she also experienced a gurgling sensation in the right chest. At times she noted belching and a sensation of abdominal fullness. Each attack would be accompanied by dyspnea in various degrees.

The systemic inventory review was essentially negative. Past medical history disclosed that she had undergone an appendectomy at age 12 and a right inguinal herniorrhaphy at age 28 without sequelae. Her menstrual cycles had always been regular and normal. The patient was Gravida 3, Para 3, Abortus 0. Each labor and delivery was without complications, except the last delivery, at which time the chest pain appeared on or about the fifth postpartum day.

The physical findings were essentially normal, except for the presence of a spontaneous pneumothorax in the right hemithorax. This was confirmed by x-ray examination on July 30, 1957. Examination of the chest, using inspiration and expiration films, demonstrated the presence of a partial pneumothorax of the right lung with approximately 1 centimeter separation between the pleural surface of the lung and the thoracic cage. There was a minute amount of fluid in the right costophrenic angle. The mediastinum was not displaced. There were extremely minimal hypertrophic changes involving the anterior margins of the vertebrae. Repeat examination of the chest on August 5, 1957, showed the right lung to be expanded. The patient was free of pain, and menstruation had ceased. She was not seen again until September 24, 1957, but reported that on August 24, 1957, she had experienced another bout of chest pain and shortness of breath at the commencement of her menstrual cycle. On September 25,

1957, x-ray examination of the chest again demonstrated a small pneumothorax. Several small areas of decreased density appeared in the extreme right apical area of the lung, which evidently represented small blebs.

On October 20, 1957, the patient was admitted to Garfield Memorial Hospital, Washington, D. C., and underwent a right thoracotomy the next day. The physical and laboratory findings at the time of admission were normal. The operation was performed by J. W. Peabody, Jr., M.D., of Washington, D. C. The entire lung appeared essentially normal. It was pink throughout with little anthracotic pigment. Palpation disclosed no masses in the lung, and inspection revealed no tissue implants or blebs. Biopsy was not done. To obviate any further recurrences of the spontaneous pneumothoraces, the entire lung was abraded with gauze as was the parietal pleura.

The patient made an uneventful recovery and was discharged from the hospital on October 29, 1957. X-ray examination at the time of discharge showed both lungs to be well expanded. There was a slight amount of linear atelectasis at the right base and a small amount of fluid in the right costophrenic angle.

Since her discharge from the hospital, she has remained free of symptoms and signs. Her menstrual cycles have remained regular, and she has had no pain or pelvic discomfort. The pelvic examination has always been entirely normal.

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THE EFFECT OF ISOXSUPRINE HYDROCHLORIDE UPON THE CONTRACTILITY OF THE HUMAN UTERUS IN LABOR

The effect of isoxsuprine hydrochloride upon the contractility of the human uterus in labor was studied in twenty patients. When given intramuscularly to ten of the patients, the general effectiveness was negligible. Of the ten in whom the drug was administered intravenously, five patients demonstrated transient changes in the uterine contractile pattern. In four of these, the uterotrophic effect was associated with hypotension, tachycardia, and decrease in the fetal heart rate.

Hans D. Taubert, M.D.

Arthur L. Haskins, M.D.

THE PRESENCE of pathologic contractile patterns in the human gravid uterus may require specific and prompt therapy. Should the abnormality be hypotonic, as in uterine inertia or uterine atony, the administration of oxytocic substances usually resolves the problem. Should the abnormality be hypertonic, as in uterine tetany or a prematurely established labor pattern, the administration of a myometrial relaxant may be indicated. Since there are no universally satis-

factory myometrial relaxing substances, any new drug with this pharmacologic property should be carefully evaluated.

Ioxsuprine hydrochloride (Vasodilan^{®1}) recently became available for investigation as a myometrial relaxant. It is said to have a direct relaxing effect upon the smooth muscles of blood vessels and the uterus (2-5). Clinical trials to evaluate the degree of myometrial relaxation that might be obtained with this substance were carried out at the University Hospital.

Method and Material

TWENTY WOMEN in the last trimester of pregnancy were selected. None of these patients had any particular medical or obstetrical

From the Department of Obstetrics and Gynecology, University of Maryland School of Medicine.

¹Vasodilan was supplied by Mead Johnson, Evansville, Indiana.

problems. Their labors were classified as false, prodromal, or established (Stage I).

Dilatation and effacement of the cervix and station of the presenting part were determined before, during, and at the end of each recording. Blood pressures, pulse rates, and fetal heart rates were recorded frequently. The readings were taken one minute after the tokograph had registered the termination of a uterine contraction. When the uterine diastole was too short to comply with this rule, the reading was taken at a mid-interval between two contractions. Uterine contractions were recorded by the Lorand (7, 8) tokograph.

Ioxsuprine hydrochloride was administered either intramuscularly or intravenously. When given intramuscularly, a dose of 10 milligrams was injected into the gluteal region. When administered intravenously, 10 milligrams of ioxsuprine was given slowly in 150 cubic centimeters of normal saline. The infusions were extended over periods ranging from ten to sixty minutes.

Results

SERIES #1 (Intramuscular injection of 10 milligrams of ioxsuprine hydrochloride)

IN EIGHT OF THE TEN patients studied, labor was well established. There was no evidence of any change in the uterine contractile pattern following the intramuscular administration of ioxsuprine hydrochloride. One patient in this group was admitted to the hospital with a clinical diagnosis of false labor. Upon administration of ioxsuprine, uterine contractions became less frequent and subsided completely five hours after the injection. The patient was discharged from the hospital to return at term for a normal delivery. The remaining patient was admitted to the hospital in prodromal labor at thirty-three weeks of gestation. She received ioxsuprine with some decrease in the frequency of contractions. The injection was repeated in three hours without effect. The patient entered active labor and was delivered approximately twelve hours after admission.

The average length of time for which tokographic recordings were made was two hours and ten minutes; the range was forty-five to three hundred and twenty minutes.

A mild tachycardia was noted in one patient. There were no local reactions to the drug injection.

SERIES #2 (Intravenous administration of ioxsuprine)

In this group, five of the ten patients exhibited some decrease in the intensity or frequency of uterine contractions within a few minutes after the intravenous infusion had been initiated.

In the patients in whom a change in uterine contractile pattern could be demonstrated, undesirable side effects occurred in four; specifically precipitous falls in systolic blood pressure to shock levels, sharp increase in heart rate, and, in one instance, a decrease in the fetal heart rate.

In two instances a decrease in blood pressure and tachycardia were accompanied by shortness of breath, headache, and vertigo. One patient required oxygen administration. Normal blood pressure was restored within minutes after the infusion was discontinued.

The severe side effects occurred when not more than 6 milligrams of ioxsuprine had been administered. There was no apparent correlation between the dose per minute and the incidence of hypotension. The total time of infusions in these four patients varied from ten to sixty minutes. Tokographic recordings were obtained for an average of more than one hour continuously or intermittently after the infusion had been discontinued. No permanent change in the uterine contractile pattern was noted.

Comment

ANY SUBSTANCE intended for clinical use in the inhibition of labor should not induce circulatory disturbances. Previous reports (1, 6) had noted that parenteral administration of ioxsuprine hydrochloride might be associated with hypotensive episodes or tachycardia. The data derived from this study suggest that the hypotensive effect of ioxsuprine occurs when amounts sufficient to suppress uterine motility are given even with the cautious administration of this substance. Doses which do not produce undesirable side effects have failed to modify uterine contractions.

There was no significant change in the uterine

contractile pattern after the intramuscular administration of isoxsuprine hydrochloride. Intravenous infusion did not bring labor to rest in any instance. A modification of the uterine contractile pattern was observed in 50 per cent of the patients, but the unwanted cardiovascular effects were clinically much more impressive.

These studies confirm previous observations concerning the antispasmodic effect of isoxsuprine upon the uterine musculature under experimental conditions. The observed effects, however, were slight, evanescent, and did not seem to affect the

expulsive forces of the uterus sufficiently to prolong labor.

No ill effects were noted upon the infants. There was no evidence of hypersensitivity and no adverse local reaction at the injection site. These findings lead to the conclusion that isoxsuprine as used in this study is not indicated in obstetrical situations requiring the total inhibition of labor.

University of Maryland School of Medicine
Baltimore 1, Maryland

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 ? ? ? Any questions ? ? ?

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The Problem of PANCREATIC CYSTS

A review of cysts of the pancreas treated at The Johns Hopkins Hospital in the past twenty years is presented. Roux-en-Y cystojejunostomy is a successful procedure in those cases where the cyst cannot be excised. Simple external drainage procedures may be indicated.

PANCREATIC CYSTS, while most commonly representing a complication of pancreatitis, may result from other causes.

A useful classification is the Cattel (1) modification of the one by Mahorer and Matson (5). The complete classification is as follows:

- I. Developmental
 - a. Fibrocystic disease
 - b. Simple cysts
 - c. Dermoid cysts
 - d. Cysts associated with polycystic disease of other viscera.
- II. Inflammatory
 - a. Pseudocysts
 - b. Retention cysts
- III. Traumatic
 - a. Indirect trauma
 - b. Direct trauma (operative and penetrating wounds)
- IV. Neoplastic
 - a. Cystadenoma
 - b. Cystadenocarcinoma

William F. Rienhoff, 3rd, M.D.

- c. Teratoma
- d. Unusual tumors

V. Parasitic

Not all of these types of cysts are encountered in a given series. An arrangement such as the aforementioned has definite limitations, in view of the fact that a cyst may lose its epithelial lining and, therefore, be indistinguishable from a pseudocyst. A series of such cases was reviewed from the files of The Johns Hopkins Hospital. Of twenty-four found in a twenty year period nineteen were pseudocysts; three, simple cysts; one, traumatic; and one, unknown. Neoplastic cysts and congenital fibrocystic disease were excluded.

A preponderance of pseudocysts is usual. These are most often characterized by a thick wall which is adherent to surrounding structures. Histologically, they have no epithelial lining and a wall composed of granulation tissue and scar. The simple cysts are thin-walled and non-adherent and have an epithelial lining. The locations in the pancreas in this group were: lesser peritoneal sac, thirteen; tail, five; body, four; head, three; un-

From the Department of Surgery of The Johns Hopkins University.

known, one. In the majority of cases in which the fluid was studied, serum amylase determinations were elevated.

The symptoms and signs of pancreatic cysts vary. The age range included the span of adult life, and an equal number of males and females were represented. The symptomatology of pancreatic cysts may be severe and prominent or, on occasion, relatively insidious. This may be determined by the presence and degree of associated pancreatitis. Likewise, another important factor in the clinical picture is the location of the cyst in the pancreas and the adjacent structures that are involved.

A history of alcoholism was obtained in ten out of twenty-four patients. Pain, usually located in the upper abdomen, was the most common and persistent symptom. Weight loss was a prominent feature, with the amount varying over a wide range to a maximum of fifty pounds. Nausea and vomiting were noted in some of the patients and tended to be of more recent onset than pain. Gastrointestinal hemorrhage was so severe in one patient as to cause peripheral vascular collapse. In another patient, only a history of hematemesis prior to admission was noted. Jaundice was present in two cases.

The physical findings consisted of a palpable mass in the upper abdomen in twenty-two of the patients and tenderness in a smaller number.

Preoperative laboratory data were not especially helpful. Several patients were found to have diabetes mellitus. In some patients, radiologic studies revealed displacement of various hollow viscera or pancreatic calcification. It is rarely possible to make a diagnosis preoperatively. Abdominal exploration is required to confirm the clinical impression.

Four basic methods of operative management are available: simple drainage, marsupialization, internal drainage, and excision. Simple drainage apparently had been unsuccessfully attempted in the late nineteenth century, perhaps because of closure of the drainage tracts. Marsupialization with suture of the cyst wall to the parietal peritoneum was first described in 1882 by Gussen-

bauer (3), a pupil of Bilroth. This method achieved popularity because of its ease and low mortality. Its use has been limited, because it may not eliminate the cyst or it may leave an annoying and persistent pancreatic fistula. The procedure may be useful, however, either as an initial procedure or a definitive one.

Internal drainage was accomplished by Jedlicka (4), in 1915, by performing a cystogastrostomy. Since then, many procedures anastomosing the cyst to other organs, such as the stomach, duodenum, jejunum, and gall bladder, have been performed.

Excisional therapy is the ideal treatment. In general, it is the unusual pseudocyst that can be excised without serious technical problems and without injury to adjacent blood vessels. Recently, sphincterotomy, either alone or in combination with a drainage procedure, has been advocated by Doubilet and Mulholland (2).

The procedures used in this series are tabulated below. It is important to note that four patients had multiple procedures and two had three operations.

Simple drainage	10
Cystojejunostomy (Roux-en-Y)	8
Excision of cyst	4
Marsupialization	3
Cystojejunostomy (side-to-side)	2
Aspiration	1
Cholecystojejunostomy	1

No operative mortality occurred.

Patients requiring reoperation were those treated by simple drainage or marsupialization. Reoperation was usually indicated by a recurrence of the cyst or a persistent pancreatic fistula. There appear to remain indications for one or the other forms of external drainage, such as critical illness, an acute process, or a situation in which the exact nature of the lesion is obscure. Anastomosis of the cyst to the duodenum is specifically suited for those located in the head of the pancreas. Roux-en-Y cystojejunostomy seemed to be the most successful procedure.

1201 North Calvert Street
Baltimore 2, Maryland

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Medical Roles and Social Procedures for Hospitalizing a Psychiatric Patient

Wayne E. Jacobson, M.D.

THE PROBLEM of dealing with a patient who needs to be in a state psychiatric hospital is a common medical experience. Effective management of this problem requires that the physician clearly understand his medical role and the social procedures by which he can implement his role.

The Physician's Role

MISUNDERSTANDING is frequent. The resultant ambiguity makes difficulties for patients and families and complicates the physician's expeditious use of skill, time, and energy.

The physician's role is the same as his role in dealing with any medical problem. The doctor *advises* and *recommends* hospitalization; he never *commits* a patient to a psychiatric hospital. He does give a written statement of the medical facts he has observed. This medical certificate simply provides a basis for appropriate action by patient, hospital, family, or community.

For practical purposes there are two procedures by which hospitalization can be effected: voluntary hospitalization and hospitalization with two medical certificates (1).

Voluntary Hospitalization

THIS IS A hospitalization procedure not well enough known and not enough utilized. Eventually, it will probably become the principal means by which patients enter state psychiatric hospitals.

The doctor's medical role is analogous to that in dealing with any medical problem. After examination, if hospitalization is deemed advisable,

this *medical opinion* is stated in writing on a form supplied by The Department of Mental Hygiene. The patient is *not required* to use it. If the patient agrees, a telephone call may be made to the admitting officer of the state hospital, at which time the medical situation is discussed. The patient is then responsible to effect his own hospitalization. No "admit" or "support order" is necessary. Financial arrangements are made at the hospital.

The medical and social advantages to this procedure are: first, the patient is not committed. He accepts responsibility for his cure and treatment. Second, only one licensed physician is required. His medical opinion, in writing, *advises* hospitalization. A psychiatrist is not required to give this opinion. Third, complicated social and legal difficulties are avoided.

Hospitalization With Two Medical Certificates

MUCH CONFUSION exists about this type of hospitalization. Two clarifying statements are in order.

First, the doctor does *not* commit. As with voluntary hospitalization, he gives a written medical opinion based on examination of the patient. He certifies as to medical fact. The physician does *not* need to be a psychiatrist; the only requirements are that he be licensed and have five years of postgraduate experience.

Second, a diagnosis is not necessary. A description of the patient's mental functioning which supports the physician's medical judgment is all that is required.

With these two facts clear as to his medical role, it is possible for the physician to make ap-

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The physician's medical responsibility in recommending psychiatric hospitalization is clarified. His role is defined in facilitating admission, both voluntary and by certification. The importance and general applicability of the family request procedures is emphasized.

32. COMMITMENT ON REQUEST OF MEMBER OF FAMILY, RELATIVE, FRIEND, ETC.

In addition to the methods otherwise provided by law for the commitment of lunatic or insane persons, such persons may be committed to institutions in accordance with the provisions of this section.

Whenever any person is shown to be a lunatic or insane by the certificates of two qualified physicians, as provided in Section 31 of this article, the superintendent, chief officer, or physician in charge of any State or licensed private institution for the care, custody or treatment of insane persons, or if such person is a veteran of any war, military occupation or expedition, the official in charge of any United States Veterans Hospital, within the exterior geographical boundaries of the State of Maryland, may receive and retain such person as a patient upon the written request of any member of his family, or near relative or friend, or the person with whom he resides, or an officer of any charitable institution or agency; provided, however, that such person, or anyone in his behalf, make a request in writing to said superintendent, chief officer, or physician for the discharge of such person and such request shall be complied with unless said superintendent, chief officer, or physician shall be of the opinion that the mental condition of such person requires his further detention, in which event such superintendent, chief officer, or physician shall retain the custody of such person and shall forthwith file petition, in accordance with Section 21 of this article, for the purpose of having the sanity of such person determined, and if the court shall commit such person to that or some other suitable institution, as provided by said section, he shall be confined thereafter until he shall have recovered, or shall be discharged in due course of law. The provisions of this article relating to the discharge of recovered patients and to the payment of the expenses of maintaining persons in State institutions shall be applicable to persons entering such institutions under the provisions hereof.

ropriate recommendations to implement hospitalization. Unfortunately, the procedures have been ambiguous (2). They can be stated clearly.

Hospitalization By Community Request

FOR THE INDIGENT mentally ill, who have no one able or willing to act responsibly for them, the county commissioners (or Department of Public Welfare in Baltimore City) are authorized by law to so act, when they possess qualified written medical opinion. They can and do secure admission for such patients, utilizing existing arrangements and forms to do this. For such patients, these local agencies are responsible for transportation and for some part of the financial responsibility. These local bodies are the committing agent.

For many reasons, including the historical development of the Mental Health Act, this pro-

cedure has been the principal means of effecting hospitalization. It is cumbersome, often of dubious legality, and unnecessary in most cases. It should be the exception rather than the regular hospitalization procedure.

Family Request Procedure

IN 1944, SECTION 32 was added to Article 59 of the Maryland Mental Health Act. This amendment was a legal necessity, as well as medically and socially wise, but for various reasons it has not been adequately known or used. It provides for a family or someone (spelled out in law) acting in lieu of family to request, in writing, hospitalization for a person who has been examined by two licensed, experienced physicians. These physicians have provided written certification of the medical facts on appropriate forms supplied by The Department of Mental Hygiene.

The physician's role is entirely medical. The family are not obliged to follow such recommendations. If they do accept medical advice, the physician's role is then to communicate the medical facts to the admitting officer of the hospital. This contact with the hospital is ethical. It provides an opportunity to discuss with the admission service the appropriate timing of hospitalization. Many patients should be seen by the hospital's pre-admission service. This contact can materially affect the usefulness of the hospital for the patient, particularly for patients who do not constitute an emergency.

By policy, emergencies are always accepted. The referring physician's judgment is not questioned; however, his contact with the admitting physician of the hospital in cases of emergency does allow the hospital to act rapidly, knowledgeably, and efficiently. Thus, patient interest is better served.

The Commissioner of Mental Hygiene, on June 21, 1960, directed the state hospitals to accept patients who are hospitalized in the above mentioned manner.

The Department of Mental Hygiene recommends wider use of the procedure contained in Section 32, Article 59, of the Annotated Code of Maryland for admission of patients to state mental hospitals. Section 32 provides that a patient may be admitted to a hospital on the written request to the hospital superintendent by ". . . any member of his family or near relative or friend, or the person with whom he resides, or an officer of any charitable institution or agency; . . ." The written request must be supported by the certificates of two licensed and qualified physicians, as specified in Sections 31 and 32 of Article 59.

The state hospitals no longer restrict the use of

this procedure to certain emergencies. Although other admission procedures as specified by law may be used, the Department of Mental Hygiene urges that patients be admitted under the provisions of Article 59, Section 32 whenever possible.

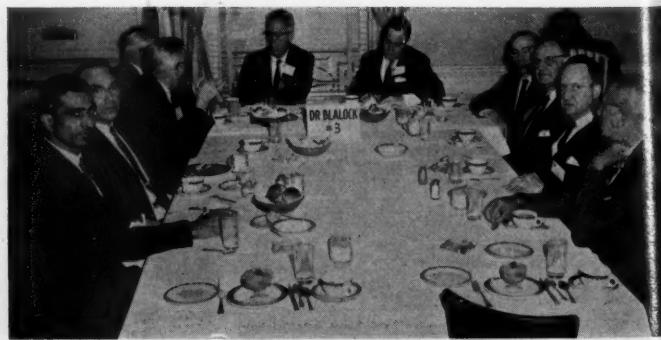
Other states and countries have adopted similar procedures to remove delays and administrative processes which often make it difficult to admit patients to public mental hospitals. Hospitalization is always stressful for the patient and family and it should not be made more so by police custody, financial investigations prior to hospitalization, and other procedures not always necessary. The "family request" admission is easier for patients and families to understand and places the responsibility for initiating and carrying through hospitalization on the family of the patient. Modern concepts of psychiatric treatment place more emphasis on the cooperation and participation of the family.

This procedure does not require "admits" or "support orders." It saves time, makes hospitalization a medical transaction, and, most importantly, defines the responsibility of family. The petitioner has the basic responsibility for effecting the hospitalization, although the physician's knowledge of community resources may be needed and should be offered. It is hoped that this will become the principal method of securing hospitalization for patients.

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1. Statutes and Rules of Procedure Concerning the Mentally Disordered in Maryland from Annotated Code of Maryland, 1957 Edition and 1959 Supplement.
2. Access to a Mental Hospital. Health and Welfare Council, Report of Committee, 1960.



Pictorial Feature

ANNUAL MEETING

1961

- ✓ *Speakers*
- ✓ *Exhibits*
- ✓ *Presidential Dinner*
- ✓ *Round Table Luncheon*





Russell S. Fisher, M.D., and Norman B. Roberg, M.D.

HISTORY

Mr. T. L. dates the onset of his symptoms to July 23, 1958, when he experienced acute onset of substernal, sharp, aching pain that took his breath away. The previous day he had been cleaning up a flooded basement in a local textile mill and stated that he caught a "cold" because of working in the wet, damp area. The chest pain alternated with pain in the small of his back. There was, on several occasions, expectoration of minimal hemoptysis. He has experienced about twelve episodes of paroxysmal, nocturnal dyspnea, together with dyspnea on exertion. The patient's appetite has been poor since the onset of his symptoms. He has vomited on several occasions. The substernal pain has occurred on several occasions since its onset. The pain is accentuated by deep breathing.

Review of systems: Occasionally has frontal headache. Has no convulsions or ataxia. Cardiovascular: see present illness. No edema. Has mild, dusky, cyanosis. Gastrointestinal: poor appetite and vomiting. Genitourinary: negative.

Past History: No previous hospitalization. No tuberculosis. Had contact with tuberculous patient, July 4, 1956, but has never had tuberculosis.

Family History: non contributory. Marital status: wife is living and well.

Social History: drinks six or seven bottles of beer in the evening. Occasionally uses spirits.

EXAMINATION

No acute distress. Patient is obese. Skeletal and muscular development

are normal. Head: normal contour. Hair and scalp are normal. Eyes: pupils are equal and react to light. Fundi are normal. Extra-ocular movements are normal. No nystagmus. Ears: negative. Nose: negative. Mouth: teeth are in poor condition. Tongue, mucous membranes and pharynx are normal. Neck: trachea is in the midline. Thyroid is not enlarged. No rigidity. Glandular: No cervical or axillary lymphadenopathy. Chest: emphysematous. Lungs: clear to auscultation and percussion. Heart: normal. Blood pressure: 140/60. Abdomen: round. Liver, spleen and kidneys are not palpable. No masses, tenderness or fluid. Extremities: no deformity or edema.

LABORATORY STUDIES

Urinalysis: albumin, 1 plus; sugar, negative; microscopic, granular and cellular casts. Hemogram: hemoglobin, 13.8 grams. Hematocrit: 42. Leukocyte count: 19,400. Blood sugar: 85 milligrams per cent. Urea nitrogen: 142 milligrams per cent. Carbon dioxide: 18 vol. per cent. Test for syphilis: negative. Blood urea repeated August 1, 1958: 144 milligrams per cent. Carbon dioxide: 14 vol. per cent.

Electrocardiogram July 28, 1958: PR .16 sec.; QRS .08 sec.; rate 75. Normal sinus rhythm with an occasional auricular premature beat. P normal. QRS, semi-vertical axis. Small Q in 3 and aVF. ST normal. T inverted. *COMMENT:* No significant abnormality.

Electrocardiogram repeated July 30, 1958. COMMENT: No change since was performed.

DR. RUSSELL FISHER: Since this is Dr. Roberg's clinical discussion, I will not detract from your major interest by telling you any-

Presented before the Clinical Conference of the Chicago Medical Society, March 2, 1959. Reprinted from the Chicago Medical Society Bulletin, November 21, 1959.

previous record. Tracing is within a possible normal variation.

X-ray of the chest: Extensive patchy, rather homogenous density occupying the medial two-thirds of each lung. This extends from the hilum, presenting a butterfly-like distribution. The peripheral one-third of each lung appears relatively clear. The heart is not enlarged, and the cardiothoracic ratio is approximately 16 to 34 centimeters. The aorta, diaphragm, and bony thorax are not unusual. *IMPRESSION:* The changes in the lungs simulate those produced by an acute pulmonary edema. Collagenous diseases sometimes present a similar radiographic finding. Pneumonia this extensive seems unlikely but cannot be entirely excluded.

COURSE IN THE HOSPITAL

Patient initially was felt to have a respiratory disease with bronchitis, possibly bronchiolitis and pneumonitis. He was treated with aerosol theoglycinate, penicillin using oxygen nebulizing mask; this treatment was preceded by eight inhalations of Vaponefrine®, using a hand Devilbiss nebulizer. He was given penicillin intramuscularly. There was symptomatic improvement. The blood chemistries were at first interpreted as indicating dehydration, but it was evident on the second test that the patient was not dehydrated and that he had a renal disturbance. On August 2, he suddenly became much worse, developed peripheral failure, went into shock from which he could not be brought out by the use of vasopressor agents. He died August 2, 1958. An autopsy

thing other than you have before you in protocol, plus one statement that Dr. Roberg asked me certain questions to which I replied, and he will tell you the questions and my replies to round out the protocol which is before you.

DR. NORMAN B. ROBERG: Thank you, Dr.

Fisher. This man was a 46-year-old white male who had apparently been entirely well until 11 days before death and five days before hospital admission. The day before he had been cleaning out a flooded basement in a textile mill, and he felt that he caught cold. By the next day he was suffering with sharp, aching pain substernally, was dyspneic, and on breathing there was a sharp, pleurisy-type pain and also some aching in the small of the back. During the following five days the appetite was poor and he vomited several times and coughed up small amounts of blood at times. He had about a dozen attacks of nocturnal dyspnea, but no chills or fever. Therefore, we have chest pain aggravated by breathing, with dull pain in the back and minor hemoptyses, and anorexia and occasional vomiting. When he entered the hospital he was not acutely ill. I asked Dr. Fisher about this, and he said that the man was 46, quite obese, and entered the hospital in no acute distress. The breathing was quiet except when he exerted himself. Thus, the breathing was essentially normal, there was no inspiratory or expiratory difficulty, and no wheezing. There was merely a mild cough with a small amount of blood occasionally, but there was no further hemoptysis while in the hospital. All he showed was a little dusky cyanosis, some shortness of breath, but the respiratory movements were normal. Physical examination was normal.

X-ray examination of the chest was distinctly abnormal with rather extensive patchy, confluent densities throughout both lungs, homogeneous in quality and spreading out symmetrically into a butterfly configuration and extending almost to the periphery. This was considered characteristic of pulmonary edema, and is sometimes seen in the collagen diseases or in uremia, especially in L. E. and periarteritis nodosa, but usually the densities are not so homogeneous, and not usually so symmetrical. One must give consideration to the question of multiple pulmonary emboli. One can have these without any evidence of venous thrombosis of the leg. With pulmonary embolism one does not usually see symmetrical changes. In pulmonary embolism or infarction, if there are sufficient pulmonary emboli to cause paroxysmal dyspnea, usually such emboli are fatal. What about pneumonia or pulmonary edema? Certainly the clinical findings sound like it, but at autopsy

it is often difficult to say whether the patient had pulmonary edema or pneumonia. Pulmonary edema and pneumonia are mutually facilitative. In pulmonary edema we know that the rich alveolar and bronchial bloody transudate makes a very fertile soil for bacterial growth, and, furthermore, in a diffuse pneumonitis pulmonary edema is frequently present. So it is often very difficult to differentiate pulmonary edema from a bacterial pneumonitis. Bacterial pneumonitis is highly improbable with a temperature never above 99 and 100. The dyspnea and cough might be due to a viral disease, but again there was no fever, the pulse was only 75, and the breathing was quiet despite the widespread pulmonary involvement. These speak against either primary pneumonia, or pulmonary edema, caused by heart failure. There was no evidence of myocardial disease on physical examination: the heart was normal in size and configuration, with no murmurs and the heart rate was 75. The blood pressure was 140/60 which is normal. The electrocardiogram had small Q waves in leads 3 and AVF, consistent with a small, old, posterior infarct. Certainly there was nothing in the electrocardiogram to suggest there was any active myocardial infarction. With the blood pressure and heart size normal, and the optic fundi normal, there is no reason to believe that this is a hypertensive heart disease with pulmonary edema. If there were pulmonary edema on the basis of heart failure, there should have been dyspnea, orthopnea, and engorged neck veins. So here we have a classic picture of pulmonary edema without any evidence of heart failure or definite evidence of pneumonia.

The laboratory work is the most significant thing. Dr. Fisher told me that daily urinalyses were done, and they were all the same. The urinalyses are the crux of the diagnosis in this patient. The quantity of urine was small, varying from 400 to 800 cc. a day. There was only 1 to 2+ albumin. Oliguria and albuminuria may be caused by progressive thrombosis of the leg veins, the inferior vena cava, and one of the renal veins. However, this causes a marked proteinuria, not merely a 1 or 2+ albuminuria. There were 20 to 50 white blood cells, and 10 to 20 red blood cells per highpowered field. Red cells can enter the urine anywhere from the kidneys down to the penis. There were, however, red cell casts. Thus we are dealing with blood from the glom-

erular tufts entering the tubules and being condensed into casts of the tubules. With red cell casts one must have bleeding from the glomerular tufts. Furthermore, very important is the fact that the specific gravity of all the urines examined was high. If one finds a high specific gravity in an azotemic patient, one can then say that the damage is primarily vascular: arteriolar or glomerular. The plasma flow through the kidneys and the glomerular filtration are reduced, and yet the renal tubular function is relatively intact. The water in the tubules is adequately re-absorbed and the specific gravity can be high. One will find, if there are high specific gravity and red cell casts, that the damage is primarily glomerular. The high specific gravity speaks also for acuteness. The question arises immediately, when we see the BUN of 142 on admission, whether this is an acute exacerbation of chronic renal disease, or acute renal disease. The first argument against chronic renal disease is the normalcy of everything else. The lack of anemia speaks against chronic renal insufficiency.

The clinical course of this patient interests me a great deal. Apparently it was quite static. The blood pressure was 142/60 and he was seriously oliguric. The CO₂ combining power had dropped to 18 volumes per cent by the first day, and to 14 volumes per cent by the day before death. Apparently, however, the treatment was directed towards the lungs. He was given a bronchodilator, and penicillin. This is satisfactory in view of the fact that he might have had some secondary bacterial pneumonitis. In any azotemic condition it is common to have leucocytosis. So this man's condition was quite static until the fifth day. He had no further hemoptysis, no more respiratory difficulty, but then suddenly developed peripheral vascular failure. One would think first of hemorrhage, but there was no evidence of it. There is not adequate evidence to consider myocardial infarction with left ventricular failure and irreversible shock. There is evidence of metabolic acidosis and hypoxia. We know that hypoxia can give rise to irreversible shock, although there is no evidence that his pulmonary edema had worsened. I would be inclined to feel that death was due partly to hypoxia, to metabolic acidosis, to advancing azotemia, and to progressive hyponatremia and hyperkalemia. In this type of acute

renal injury, sometimes the patient can be tided over by hemodialysis with the artificial kidney.

Now what was the basis of the disease as the dynamics are concerned? I feel that with the high specific gravity and the red cell casts one should look for some acute disease primarily involving the cortex of the kidney. One of the commonest causes is infarction of the kidney, but here we have no evidence of auricular fibrillation as a source of emboli. There is no evidence of occlusive vascular disease which could cause microinfarcts and glomerular bleeding: malignant hypertension, periarteritis nodosa, or lupus erythematosus. One can have a hypersensitivity angiitis with diffuse inflammatory changes in the small arteries throughout the kidney. Penicillin and the sulfonamides can occasionally cause such a reaction, but there is no history of their use. With respect to other hypersensitivity states, one must give consideration to the classic one, acute glomerulonephritis. There was no history that this patient had any preceding illness. An elevated ASO titer would suggest recent streptococcal infection followed by acute glomerulonephritis. The pulmonary edema in patients with acute glomerulonephritis is not related to the height of the NPN, but is a concomitant finding. One may find pulmonary edema in acute glomerulonephritis with the NPN only 50 to 75 mg. per cent. There is a heavy fibrinous exudate into the alveoli. Sometimes the exudate is hemorrhagic. The walls of the alveoli may show hemorrhage and necrosis, quite similar to the picture found in the lung in rheumatic pneumonitis. The pulmonary edema, acute azotemia, red cell casts, and high specific gravity are consistent with acute glomerular inflammation.

What about infections? This man was cleaning a flooded basement, and he might have contracted Weil's disease. But he had no headache, no prolonged fever, and with a spirochetal infection the liver damage is more obvious than renal injury. Is there any possibility of poisoning? What does it say the man had been doing? There is nothing said about there having been a fire in the basement, or about the use of carbon tetrachloride fire extinguishers. We know that sudden severe exposure to carbon tetrachloride may lead to severe bronchopneumonia and pulmonary edema. Very often there is an acute nephropathy.

With severe acute damage to the kidney there can be hemorrhagic glomerulitis and severe azotemia. Sometimes, after inhaling the fumes, the lungs, kidneys, adrenals, and pituitary will be primarily affected and the liver to a lesser degree. Liver damage usually is more severe after swallowing the carbon tetrachloride. One must give serious consideration to some nephrotoxic agent such as carbon tetrachloride. I feel that the differential diagnosis is reduced to that of an acute glomerular nephritis with an accompanying stubborn pulmonary edema, and, more likely, a nephropathy due to some nephrotoxic agent similar to carbon tetrachloride.

At this point I will leave it to Dr. Fisher. Any further questions we can discuss later.

DR. FISHER: With the intention of baiting you just a little, what is your impression of the liver injury, since this is usually a sign of carbon tetrachloride poisoning?

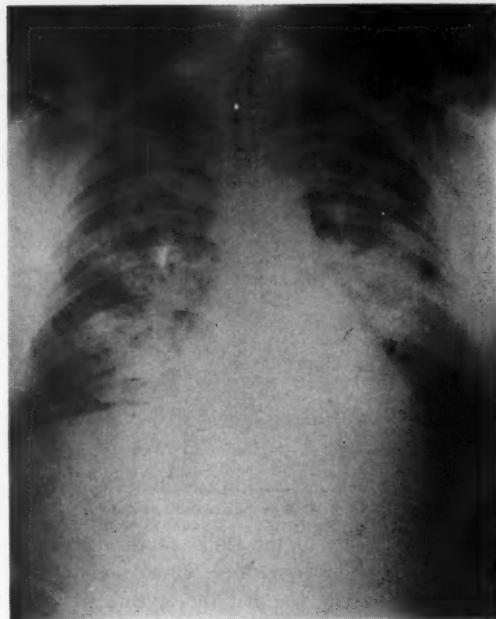
DR. ROBERG: I have had too little experience. I have seen a few patients with severe carbon tetrachloride poisoning, and they showed jaundice early in their disease.

DR. FISHER: Do I hear any suggestions from the audience as to additional diagnoses? Yes, cirrhosis of the liver is a possibility. This must be entertained in an individual, even with a so-called normal history. As a matter of fact, I thought I might just tell you the gross autopsy findings first.

Within the head there was nothing of significance. Multiple sections of the brain showed no lesions.

When the body cavities were opened, there was a little bit of excess fluid in the pericardial sac, and some significant pleural fluid on each side. The heart immediately is very significant; it weighed 560 grams; and there was neither coronary disease nor evidence of myocardial scarring. The left ventricle was hypertrophied, so he had carried some hypertension at some time, but this was not sufficient to cause the tremendous cardiac enlargement.

The lungs weighed 2700 grams total, and on cut section exuded large amounts of serous fluid, and one, on feeling them, got the impression they were a little firmer than in ordinary pulmonary edema, and, while the consolidation of pneumonia was not recognizable, one got the impression of a severe bronchopneumonia.



X-ray of lungs showing butterfly disposition of increased density.

The kidneys weighed 250 grams each with relatively smooth cortical surfaces and distinct widening and blurring of the demarcation between cortex and medullary structures.

This is an x-ray picture of the lungs. I propose to offer you the best x-ray picture obviously. Here we have, as was already mentioned, the butterfly disposition of the increased densities throughout the lungs.

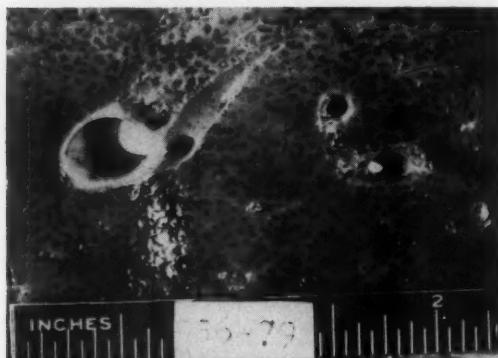
On microscopic examination, let us look at the lungs for a moment and see if we can understand the tremendous pulmonary edema.

This slide shows a low-power magnification, and one type of change that was actually one of the more significant findings, that is in the hyaline membrane which one sees in a good many of the alveoli. It consists of protein which has become dense enough so that it clings to the alveolar surfaces, and it interferes with respiratory exchange. He has also in some areas a mild inflammatory infiltrate.

This slide shows a more edematous area with less inflammatory infiltrate, more of the classical pulmonary edema formation, and yet, even here one gets the impression that fibrin is beginning to form into a hyaline membrane.

This is still another slide of the lung showing

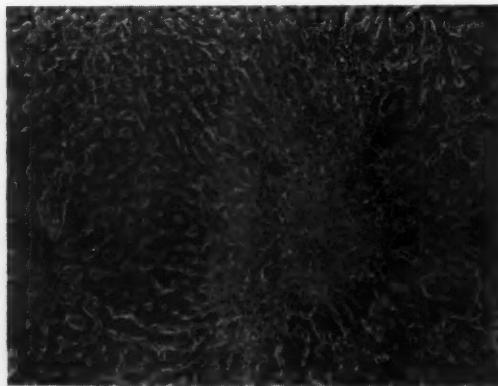
greater development of this same process with clumps of coagulated fibrin, some PMN's here and there, and fairly typical pulmonary edema with associated fibrin deposition.



Gross of liver showing central necrosis.

This is the last of the slides of the lung, and probably the oddest one. Here under higher magnification you can see that the alveoli are filled with this coagulated fibrin, and here you can see fibroblasts. Certainly here the fibroblasts are beginning to do something with this mass of fibrin which has been exuded into the alveolar spaces.

This is the gross picture of the liver. Even here you can see that there is evidence that he did have significant liver disease, but the clinicians attention had not been drawn to it. This



Low magnification microscopic of liver with central necrosis.
is the pattern of gray liver around an area of dark red congestion.

Under higher magnification this is not a true nutmeg liver, but is a pretty good imitation of it.

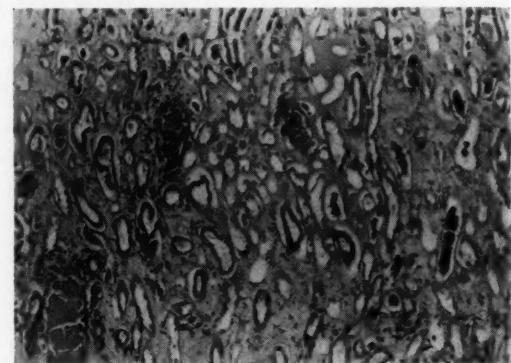
Here is a low-power photomicrograph. You will notice that in the outer areas the lobules are

well preserved, but the central zone is completely eradicated in many of the lobules.

This is a greater magnification. Here is the central vein in this region. Everything in the central one-third of the liver lobule has completely disappeared.

This, under still higher magnification, shows some evidence of regeneration. Here is a liver cell, probably in mitosis, and here is a liver cell with two nuclei. One would accept this as early regeneration of the liver parenchyma.

This slide is one of two sections of kidney which I shall show you, with massive hemoglobin accumulation in the distal tubules, and with, in some areas, a little bit of cellular infiltrate. Here is a dilated tubule filled with inflammatory components. Here again is tubular epithelial necrosis,



Low magnification of kidney with lower nephron nephrosis.

and here again inflammation. This is the so-called tubulovenous shunt of the lower nephron nephrosis.

In this next slide I see no red cells in this particular preparation, but the obstruction is quite typical of a lower nephron nephrosis from whatever disease it may have come about. I believe that is the last slide on this case.

Perhaps we might have a little discussion about what this means to the pathologist. Obviously even though there was no clinical evidence, this man had a combined pulmonary, liver and renal process with little febrile reaction, with little to suggest infectious disease but plenty to suggest a toxic phenomenon. When one sees this lower nephron disease coupled with centrolobular necrotic zones in the liver it can be assumed that one is dealing with an exotoxin, and carbon tetrachloride is the most likely. Poisoning by certain

mushrooms definitely can produce an identical liver and kidney picture. The history of mushroom ingestion obviously must be checked in order to establish a differential diagnosis. So we went back to look for additional history from one of the men who cleaned out the basement with him, and he couldn't tell us anything that had happened. We asked his wife about it, and she said nothing unusual had happened. We talked to some of his co-workers and they were not able to contribute anything. Finally we nailed down the engineer on the job, and he said, "Maybe I do know something. There is an electric motor down there on the floor, and a nearby stream raised and flooded the basement, and maybe in trying to dry it out they used a Pyrene fire extinguisher which was down there." We looked and there it was, and it was a one gallon size. Although this engineer had not been right there, he found that the workers had squirted the fire extinguisher on the electric motor in trying to dry it out. This patient had been in and out of the flooded cellar during the time they were cleaning it up. They had used Pyrene to wash down the motor, and the net result was they used three and a half gallons of it. By actual measurement, the room was 30x30x10 to 12 feet in height, and this was certainly a very small room and three and a half gallons of carbon tetrachloride to be used. The only ventilation was a circular window four feet in diameter at one end, so this man certainly had every reason to be exposed. Why did he have the poisoning and none of the other workers? I do not know. His wife denied he was an alcoholic, but we know certainly they are far more prone to get serious liver injury and get carbon tetrachloride poisoning than the non-alcoholic individual. None of the other workers was seriously ill as a result of this exposure, although several were in the area during that afternoon. The plant foreman said they were down in the basement not longer than an hour, and probably less. There was nothing else of significance noted other than the fire extinguisher.

In summary, I would say that this clinical and pathologic type of poisoning is not necessarily limited to carbon tetrachloride. There are other solvents which can cause it. However, carbon tetrachloride, nine times out of ten, is the one which is responsible. We had these same findings

in an alcoholic fellow, who, while on a binge, and was not able to get ordinary wine, during a period of a week had whiskey, a bottle of Dago Red, then drank four ounces of Eau de Cologne, and then some after-shave lotion, and also a little shoe polish. Such a combination can produce an identical liver and kidney picture to that which led to this death. We had all the empty bottles when we went to remove him, and by analyzing the few drops left in each of the bottles, we were able to establish that there had been no carbon tetrachloride in any of it.

The other two or three slides illustrate the more common incidence of the same disease.

This slide shows the disease in a chap who worked in a place where he did drycleaning. He was also a chronic alcoholic, and one night he took home a bottle of cleaning fluid for his wife to use in spotting his clothes. She knew he was a drinker, and she put the bottle on the shelf with the whiskey. He came downstairs a little later and asked her for whiskey. She told him where it was, and before he realized it, he had poured it out of this bottle instead of out of the bottle of whiskey. In a week he was dead.

This slide shows a liver and kidney which are very similar to the one we just showed you. The remarkably swollen cortices of the kidneys which are pale made them stand out against the darker medullary portions.

In this slide the histologic picture is almost identical. Again this is an individual who died of carbon tetrachloride poisoning which was environmental in that he inhaled the fumes, and he had pulmonary edema rather than purely renal and liver damage. Of course, the clinicians did not have any inkling of the carbon tetrachloride inhalation until we did the autopsy.

The lesson I would leave with you, if no other, is that this case illustrates the type of findings our medical examiners see most in carbon tetrachloride poisoning. In the last five years, we have seen 10 cases, and only in three of the 10 was it ever recognized clinically that it was due to carbon tetrachloride. In the others, it was simply picked up by going back over the history. We have found that the average house staff man does not pick it up because the alcoholic will not give the history. But the individual who services fuel oil, who spills a little and then washes it up with carbon tetrachloride, will attach no significance

to this, and neither will the individual who is casually exposed to solvents he is not himself using so frequently.

In this case the industrial use of fire extinguishers came up and we went and inquired at the plant, and they said they did not use carbon tetrachloride for washing off electrical parts because they knew of the danger. They had taken it out of the electrical shop, but the enterprising, if somewhat less erudite foreman, had undertaken to use this Pyrene in trying to dry out the electrical circuit in the basement, and had inadvertently gotten into trouble.

DR. ROBERG: I saw a patient with a similar condition several years ago. This man had recently become an amateur photographer and had built himself a dark room under the stairs in a room with no ventilation. It was a very little dark room. He had finished splicing together a long reel of film. Then, wishing to inspect and to clean the film, he pulled the film through a view box with one hand while holding cotton pads wet with carbon tetrachloride in the other, with the film between the cotton pads. He held the pledges of cotton within about six inches of his face as he cleaned and viewed the film at the same time. For about an hour and a half he was sitting there inhaling carbon tetrachloride. This was in a small closet which was completely unventilated. He came into the hospital jaundiced, with heavy albuminuria, and died from hepatic insufficiency.

I think, Dr. Fisher, this man's urine may very well have shown bilirubin if it had been looked for.

DR. FISHER: I have no doubt this is true because he had real liver injury. For any of you who happen to be plant physicians or in industry, I would cite a very recent decision along this line which might interest you. The decedent undertook to use carbon tetrachloride packed by the defendant for cleaning purposes, so hour after hour he inhaled the fumes. In two weeks carbon tetrachloride poisoning caused his death. The action was based on the inadequacy of the labeling to

show the dangers and the fatal potentials of the liquid. It was just labeled as being useful as a solvent for fats, oils, varnishes, and so forth. It warned that the vapor was harmful and that the liquid should be used with adequate ventilation, and that prolonged and repeated breathing of the vapor should be avoided, and that prolonged contact with the skin should be avoided. The plaintiff was allowed to introduce these various labels. The decedent had been thoroughly warned of the dangers of the liquid, but even though the testimony showed that he knew breathing of the vapor should be avoided and that it should be used with adequate ventilation, the net result was that when the case was decided the verdict was in favor of the defendant's family in the amount of \$160,000.

The legal comment on it goes something like this. "There is a developing body of law which says that the plaintiff should be favored in the courts, because, although he was adequately warned, the carbon tetrachloride is blamed, and he was blamed for using such a volatile solvent with ventilation which was not adequate." The court in this instance said, "Since there was a difference in labels between the different manufacturers and he used a less effective label, he now is liable when bad results ensue from the use of such chemical." This is not only true in carbon tetrachloride with bad results, but in any other case in which an insecticide is not considered to be labeled sufficiently. This emphasizes the fact that a plaintiff may introduce other and more adequate information as to what should have been done by your manufacturer or your employer or your company which did not use all the precautions, and a bad result ensued. This bothers you in the light of whether you are safe in anything these days with respect to being held responsible for a bad result or the death of an individual who really should have used better judgment and did not.

DR. COYE MASON: If there are no questions, I wish to thank Doctors Roberg and Fisher for a most interesting case.



ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

MEDICOLEGAL COMMITTEE FORMED

After hearing a talk by Baltimore attorney **Theodore C. Waters, Sr.**, Allegany and Garrett County physicians and lawyers formed a joint Medical and Legal Committee. This committee is similar to the one in Baltimore City, where court action and speedy justice are expedited by having accurate information for the judges and attorneys on both sides. Many problems common to both groups, such as drug addiction, drunken driving, health laws, and sanitation, might be better handled.

Physician representatives on the committee are **W. A. VanOrmer, M.D.**, **Donald B. Grove,**

M.D., and **Robert Feddis, M.D.**, all of Cumberland.



Left to right: William N. Geppert, Cumberland attorney; Theodore C. Waters, Sr., guest speaker; George M. Simons, M.D., president of the Allegany-Garrett County Medical Society.

PERSONALS

Physicians attending the Annual Meeting of the Medical and Chirurgical Faculty were: Doctors **George M. Simons**, Carlton Brinsfield, **Earl R. Paul**, **William P. James**, **Thomas F. Lewis**, **Alvin Walters**, **W. O. McLane, Jr.**, **A. J. Mirkin**, **Donald B. Grove**, **James G. Stegmaier**, and **Leslie E. Daugherty**. **W. O. McLane, M.D.**, of Frostburg, assumed the office of vice-president.

The annual spring meeting and educational seminar of the Maryland Society of Pathologists met at the home of **Benedict Skitarelic, M.D.**, deputy medical examiner for Allegany County. Dr. Skitarelic is a past president of the State Medical Society, a member of the Council of Pathologists for the State of Maryland and a national assemblyman for the American College of Pathologists.

At the Post graduate Assembly for nurses, held in May, **Leland Ransom, M.D.**, discussed "Gynecological Surgery," **A. J. Mirkin, M.D.**, talked on "General Surgery," **Wyand Doerner, M.D.**, spoke on "Neurology," and **S. G. Weisman, M.D.**, discussed "Metabolism."

Dr. and Mrs. Robert Feddis, Cumberland, announced the birth of a daughter, Noreen, on May 23.

In an emergency in life, there is nothing so strong and safe as the simple truth.

—Charles Dickens

WRITE A PAPER—WIN A PRIZE

Southeastern Surgical Congress announces its prize scientific paper award contest open to residents of approved hospitals in the southeastern states.

Papers are due at the Congress office, 340 Boulevard NE, Atlanta 12, Georgia, before December 1, 1961. First prize is an all-expense paid trip to the meeting at Louisville, Kentucky, March 5, 6, 7, 8, 1962, plus a cash award.

Ira A. Ferguson, M.D.
Chairman of Committee

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative



The Executive Board, on Friday, April 11, continued the exemplification of the active spirit guiding the Society. Affairs and problems that have come up many times before were gone into thoroughly once again by this 1961 Board. Opinions are easily voiced. Agreement comes after liberal exchange of ideas and experiences.

The excellent report of the Woman's Auxiliary, through its president, Mrs. Raymond V. Rangle, was discussed and accepted with thanks.

A member wrote proposing that a closed circuit television operation be instituted among members of the Society for postgraduate education. This seemed to be a rather grandiose idea to the Board, particularly since a nationwide attempt along these lines had fallen flat in the Baltimore area. Nevertheless, a committee is to be appointed to follow up the suggestion and see what good can be derived from it.

A member of the Executive Board reported on the cultist-physician proximity mentioned at the last meeting. Investigation proved the situation to be just that. The physician consulted older physicians in the area and was advised that there was no reason why the physical office space could not be leased, since there was to be no associative arrangement. Following the entering upon the contract for lease of office space, other senior physicians had expressed dismay at the breach of AMA ethics. The Executive Board is advised that the contract has been cancelled as of its one year termination date. No official action, therefore, was deemed necessary.

An annual reminder to Baltimore units of the Maryland Hospital Association regarding the Rangle Resolution was favored. The type of letter to accompany the reminder was considered from many points of view. Although the State Society has a similar committee, it was emphatically held that hospitals in the city should be

reminded that whatever support the City Society can give them is available for the asking. This is in addition to help the State Society makes available to all hospitals in the state. A simple reminder to the hospital administrators and chiefs of staff was agreed upon, with no paraphrasing of the intents and purposes that are embodied in the Rangle Resolution itself.

The B.C.M.S. insurance program came up for review again. The Executive Board earnestly desires to withdraw the B.C.M.S. from the insurance business; as one member expressed it: "To effect a strategic withdrawal as best it can, without any of its members getting hurt in the process." In view of the overlap of the city's former program and the burgeoning Faculty insurance program, the Executive Board, in probably the longest discussion of this day, decided that an insurance committee should be appointed. To correlate the two programs and effect the strategic withdrawal of the City Society.



A regular meeting of the Executive Board was held Tuesday, May 9. A member of last year's Insurance Affairs Committee had been asked to bring the 1961 Executive Board up to date about our insurance commitments. He gave an excellent review of the four insurance plans in which we are involved.

1. *Disability* insurance is now sponsored by the Faculty through the same carrier. With the Faculty active along the same line, the City Society was advised to cease active sponsorship.

2. *Life* insurance is almost the same situation. Of the four, this one, if dropped, would entail the only difficulty for member-subscribers. Age limitations might prevent members from transferring to other plans and cause them to lose the coverage they now enjoy. The Faculty has taken no action yet. Advice was that the City Society

defer action pending the Faculty's decision. If the Faculty does take over here, we should drop it, essentially as advised for the first plan.

3. *Professional liability* is sponsored by the City in a plan different from the Faculty's. Joining the Faculty in its choice was recommended.

4. *Catastrophic hospital expense* has long been placed with one insurance company by the City Society. Here, too, the Faculty has since approved a different plan, which is more inclusive. It costs about fifty dollars more per year, but, in our advisor's opinion, the additional weekly benefits more than offset the added cost.

The Executive Board accepted with thanks this digest of the situation, ably organized and presented.

Next the Board considered a letter bitterly assailing an article in the local paper based on a report of the Joint Anesthesia Study Committee, forwarded to us by its chairman. In the newspaper article, emphasis was placed on *errors* in anesthesia and exaggeration of *faults* of anesthesia in Maryland. Implication was made that hospitals concealed facts. The complaining letter stated that the news release "had set anesthesia back about a generation." According to the chairman of the Joint Anesthesia Study Committee, the information in the news article was extracted from the April 1961 edition of the "Baltimore Health News." Its material, in turn, was based on an article from the *Journal of the American Medical Association* for 17 December 1960. The chairman went on to reply, "Insofar as I know, no one active in the affairs of the Study Committee, the Medical Society, or the Health Department was interviewed with regard to the newspaper item . . . Many newspaper reviews and articles taken from professional journals present only a small part of the information available. This happens usually to be that fragment most likely to attract the attention of the public and to sell papers."

The Executive Board deplored such distorted, out of context, irresponsible reporting. It held that a factual report should include acknowledgement of the fact that Baltimore was one of the first, if not *the* first, town in the nation to establish a Joint Anesthesia Study Committee and a Fetal Mortality Committee to improve medical practices in these fields. Our study committees have served as pilot models for similar groups

in other cities. (This, of course, escaped the press entirely.)

In its deliberations, the Board recalled the sad coverage given the recent state medical meeting. The resolution regarding doctors' insignia on automobiles, certainly a trivial matter, received full play in the news, whereas resolutions of a much more fundamental character were ignored entirely. Members are invited to offer suggestions whereby the right of the public to have significant medical affairs intelligently reported could be protected without undermining freedom of the press. Medical matters and articles are misquoted or quoted out of context elsewhere in this country. It reached such proportions that the AMA and some other large groups establish news release bureaus at their big meetings to give the press authoritative data to draw from. The AMA has codified a set of guides for press releases, we are told. It is to be hoped that improvement may be brought about locally.

The Baltimore Ear, Nose, and Throat Society, close on the heels of the Ophthalmological Section of the Baltimore City Medical Society, has requested that B.C.M.S. sanction the insertion of the words "practice limited to ear, nose, and throat" after the names of its members in the Yellow Pages telephone directory. The legality of such listing under the Medical Practice Act of the State of Maryland is under scrutiny. To date there has been no edict from the State. The Board will wait for the ruling of the Attorney General before giving any sanction.

The suggestion of closed TV instructional programs was followed up by our Committee on Public Information. It developed that a program on postgraduate education in Washington, D. C. uses such a system. The cost was blandly put at half million dollars to obtain the facility, without personnel. This came as such a shock to the Committee that interest evaporated. The Executive Board was satisfied not to recondense it.

Delinquent memberships were reported by the treasurer. Six individuals, for one reason or another, have paid no dues for 1960 or 1961. One or two have items of pique which defy appeasement. The treasurer was directed to call the delinquency once more to their attention and, at a cutoff date, to notify them that their membership in the City Society had terminated. Consequently, they lose membership in the Faculty,

the AMA, and collateral societies for which AMA membership is prerequisite. Some professional liability insurance carriers require membership in the local medical society as a condition of coverage. Physician's defense is lost unless dues are paid before the end of each January. Suits based on acts in the lapsed year are not covered by Physician's Defense even though such coverage may be obtained later upon reinstatement. Reinstatement requires reapplication and payment of all arrears.

A final discussion regarded reconciliation of membership requirements in City and State constitutions. The City Society, more liberal, requires members to be active, except in a few restricted categories which entitle them to associate membership. The State Society requires several groups to be associate, others may be active. The City Society's representative to the Faculty's Planning Committee, which will consider this matter, asks anyone with strong convictions to communicate his arguments to him regarding requirements for active as against associate memberships. Some members say they know what

they do *not* want to happen, being at a loss for a more positive approach and effective phrasing of what they *do* want and how to accomplish it.

FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D.
Journal Representative

The regular May meeting was held May 16 at the Hotel Frederick. The speaker of the evening was **M. Elliott Randolph, M.D.**, associate professor of ophthalmology at Johns Hopkins. Dr. Randolph gave a formal lecture on "Uveitis," which wafted my thoughts back to medical school days.

In the business meeting which followed, **Frederick J. Heldrich, Jr., M.D.**, reported on the actions taken by the House of Delegates at the annual meeting of the Med-Chi.



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MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.

Journal Representative

Those from Montgomery County Medical Society attending the meeting of the American Academy of General Practice at Miami Beach, Florida, were: **Doctor and Mrs. Sam Allen**, **Katharine Chapman, M.D.**, Doctors Glenn and Carolyn Pincock, and Doctors Dejter and **William S. Murphy**. **DeWitt DeLawter, M.D.**, had an exhibit on "Oral Drugs for Diabetes."

Austin B. Rohrbaugh, Jr., M.D., spoke to the Dorchester County Medical Society about "Orthopedics in General Practice." He also addressed the Suburban Nurses Club at North Four Corners Recreation Center on "New Procedures in Orthopedics."

Peter A. Santucci, M.D., addressed the PTA of Whittier Woods Elementary School on "Emotional Problems in School Children."

Frederick Y. Donn, M.D., spoke to members of the Civitan Club, at the Mayflower Hotel,

on "Cancer Education." He showed a film entitled "The Other City."

Clifton R. Brooks, M.D., spoke to the Bethesda-Chevy Chase Public Health School Nurses. His topic was "Public Health Aspects of Aerospace Medicine."

Cyril G. Hardy, M.D., told the eighth and ninth grade science class of Springbrook High School, Silver Spring, Md., about "Narcotic Addiction."

At the general meeting of our society, **Alexander Izviekov**, third secretary of the Soviet Embassy, talked about "Medical Education and the Health Program in the Soviet Union." We are featuring speakers on controversial topics at our general meetings, and many of our members seem enthusiastic about this type of program.

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WASHINGTON COUNTY MEDICAL SOCIETY

JOHN D. TURCO, M.D.

Journal Representative

The regular dinner meeting of the Washington County Medical Society was held at the Venice Restaurant on May 18, 1961. The Society was pleased to have as its guests the Woman's Auxiliary to the Medical Society. **Dalton Welty, M.D.**, welcomed the guests and gave a special welcome to **Mrs. R. T. Binford**, the new president of the Woman's Auxiliary. He also thanked them for the many things they have done for the Society over the years.

Joseph C. Crisp, M.D., Program Chairman, introduced the mystery speaker of the evening, **J. H. Kehne, M.D.**, who spoke on rose cultivation and the history, growing, and exhibition of roses. He then showed some slides of dif-

ferent kinds of roses. This part of the program was especially enjoyed by the ladies.

The film "Project Hope," depicting the S. S. Hope in action in the South Pacific, was shown. This was a most interesting film.

Sidney Novenstein, M.D., presented a flower arrangement to **Mrs. Archie Cohen**, out-going president of the Women's Auxiliary. Mrs. Cohen thanked the Medical Society on behalf of the ladies for having them as their guests at the meeting.

Bender B. Kneisley, M.D., made a motion that the business meeting be postponed until a later date. This was seconded and carried unanimously.

NATIONAL LEAGUE FOR NURSING FELLOWSHIP PROGRAM

The National League for Nursing announces continuation of its fellowship program, which is made possible by a grant from the Commonwealth Fund. The program has been in existence since Spring 1955. Since that time, a total of 174 fellowships have been awarded: 140 to candidates for the doctor's degree and 34 to candidates for the master's degree.

RESOLUTIONS • • •

Medical and Chirurgical Faculty

All resolutions to be presented to the House of Delegates at its meeting on Friday, September 15, 1961, *must* be in the Faculty Office, 1211 Cathedral Street, Baltimore 1, *no later* than Friday, July 21, 1961.

OBITUARIES

CECIL BAGLEY, M.D.

Cecil Hopkins Bagley, M.D., 67, died on April 15. He was the first resident of the Wilmer Institute of The Johns Hopkins Hospital and subsequently became an outstanding ophthalmologist.

Dr. Bagley was born in Harford County, the son of a country doctor. He studied medicine at Johns Hopkins, receiving his medical degree in 1921. It was in 1925 that he became the first resident of the Wilmer Institute; two years later he became assistant to Dr. Wilmer, founder of the eye clinic.

In 1959 Dr. Bagley was named emeritus instructor at the Johns Hopkins University School of Medicine, where he had taught ophthalmology since 1928.

He was a speedboat enthusiast and had set several world speed records in his younger years. In 1935 he won the Ritchie Cup.

Dr. Bagley is survived by two sisters, Mrs. Charles Clagett, Fort Pierce, Florida, and Mrs. Frank Harbaugh, of Harford County.

WALLACE MOOK, M.D.

"Because of his untiring efforts to give personal attention to his patients, far beyond the call of duty, Dr. Wallace Mook was one of the most beloved physicians I ever knew," said a former associate in commenting on Dr. Mook's untimely death. He died at his Silver Spring home at the age of 51.

Born at Ambridge, Pennsylvania, he attended high school in Erie and Mount Vernon Academy at Mount Vernon, Ohio. He received his B.S. degree from Washington Missionary College in 1934 and his M.D. from the College of Medical Evangelists in California. He interned at North Hudson Hospital, Weehawken, New Jersey, and the Margaret Hague Maternity Hospital in Jersey City.

He came to Montgomery County in 1937 and, upon receiving his Maryland license, he set up practice as a general practitioner in Takoma Park. He was on the active staff of the Washington Sanitarium and Hospital and a courtesy member of the staff at the Suburban Hospital and Leland Memorial Hospital.

Dr. Mook was a member of the Montgomery County Medical Society, the Medical Society of the District of Columbia, and the Columbia Chapter of the College of Medical Evangelists Alumni Association. Active in the Sligo Seventh Day Adventist Church, Dr. Mook was a member of the Board of Elders of that church, which is the largest in the world of that denomination.

EDWARD P. SMITH, M.D.

A former obstetrician-in-chief of Mercy Hospital, Edward P. Smith, M.D., died on April 22. He was 76. He had joined the staff of Mercy Hospital soon after his graduation, in 1912, from the University of Maryland School of Medicine.

Doctor Smith was a former secretary of the Baltimore City Medical Society and had been a member of the House of Delegates of the Medical and Chirurgical Faculty. Among his other professional associations were the American College of Surgeons, the Southern Medical Association, and the Gynecological and Obstetrical Society of Baltimore.

He is survived by his wife, Mrs. Loretto Muth Smith, and a son, Lt. Col. Edward P. Smith, Jr.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

(Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society)

Howard W. Jones, Jr., M.D.
Chairman

The Committee for the Study of Pelvic Cancer has met monthly throughout the year for the presentation of cases for discussion as a part of regularly scheduled meetings at a hospital or one of the county medical societies. In April the Committee met with the visiting staff of the North Charles General Hospital; in May with the Cecil County Medical Society at North East, Maryland.

Abstracts of case discussions:

The patient was 47 years old, married, gravida 4-0-1-3. She gave a history of regular menses to April 1960. At this time periods became profuse and prolonged, irregular as to interval, with intermenstrual spotting. Onset of postcoital bleeding occurred in May. She says that she consulted her physician soon after the onset of these symptoms. A pelvic examination was made, and she was told that her symptoms were due to the menopause. Oral medication was prescribed. She remained under the care of this physician, and in September of 1960 he advised her to enter the hospital for a dilatation and curettage and biopsy of the cervix. She was admitted to the hospital in late September.

Diagnosis: Carcinoma of the cervix, international classification, stage II b.

Treatment: Radiation therapy.

CHAIRMAN: This case is open for discussion. I would be glad to hear any comments that you may wish to make.

PHYSICIAN: This abstract says that a pelvic examination was made, but do we know if this was

a speculum examination or only a bimanual examination?

CHAIRMAN: We do not have definite information from this physician. We write the doctors requesting information, but we do not always get a reply.

PHYSICIAN: Certainly a speculum examination should have been made.

COMMITTEE MEMBER: I think everyone will agree to that.

CHAIRMAN: As to classifying this case, is there patient delay?

PHYSICIAN: It is hard to say from the information given here. The patient began to have irregular periods and intermenstrual spotting in April and postcoital bleeding in May. She says she went to the physician soon after she began to have these symptoms. If she went to the doctor in May, I would assume that she was within your thirty day rule and that there was no patient delay.

CHAIRMAN: How about the physician?

PHYSICIAN: Do we know whether or not a Papanicolaou smear was ever taken in this case?

CHAIRMAN: According to our information it was not.

PHYSICIAN: I would think this was definite doctor delay.

PHYSICIAN: I am not sure that I agree. Wouldn't it be reasonable to explain these symptoms on the basis of the menopause; a 47-year-old patient with irregular bleeding? We are being Monday morning quarterbacks.

CHAIRMAN: With intermenstrual spotting or bleeding, I do not think you can assume that the symptoms are attributable to the menopause. If the only irregularity is the interval between menses, that could be a normal menopausal symptom; but any intermenstrual bleeding is a worrisome symptom.

COMMITTEE MEMBER: If this was staged as a II b at the time of the dilatation and curettage in September, there was probably a visible lesion at the time the patient first went to the doctor. If a speculum examination had been made, the cervix should have been grossly suspicious.

PHYSICIAN: Would you have done a curettage and biopsy, in this case, when the patient had her first profuse period and some slight intermenstrual spotting?

CHAIRMAN: That would have depended somewhat on the pelvic findings and the inspection of the cervix. I would certainly have taken a Papanicolaou smear.

PHYSICIAN: We see many patients in this age group with profuse and irregular periods. Do you think all of these patients should have a dilatation and curettage and biopsy?

COMMITTEE MEMBER: If the patient's symptoms include intermenstrual spotting or bleeding, I would not hesitate. With this symptom, I should think the incidence of carcinoma might be as high as fifty per cent.

COMMITTEE MEMBER: If an adequate pelvic examination had been made in this case, with inspection of the cervix, I think it highly probable

that the lesion would have been obvious. In any case, a Papanicolaou smear was indicated.

COMMITTEE MEMBER: The least the patient should have had was a speculum examination and a Papanicolaou smear and then follow as indicated.

CHAIRMAN: We are apparently agreed then that there was delay in establishing the diagnosis in this case.

PHYSICIAN: In this particular age group, don't you think you can follow a patient with these symptoms for a month or two if a pelvic examination is made and the cervix appears to be negative?

CHAIRMAN: Intermenstrual spotting is an exceedingly worrisome problem, and you can't ignore it.

COMMITTEE MEMBER: In this case the patient also had postcoital bleeding, which is another good reason why she should have had a biopsy long before she did.

COMMITTEE MEMBER: With these symptoms of intermenstrual or postcoital bleeding, even if the cervix appears normal, you are taking a risk with a fatal disease if you do not make the examinations necessary to establish or rule out the disease. It is an unnecessary risk to take.

The patient was a 63-year-old widow, gravida 3-0-0-3. She gave a history of an uneventful menopause in 1938. She had no postmenopausal bleeding or discharge until April 1960, when she had moderate bleeding for one day. She consulted her physician, and a pelvic examination was made. The physician reports that inspection of the cervix showed an erosion. He advised the patient to go to a gynecologist or to the hospital clinic, but she did not wish to do this. She returned to this physician twice in the following month. Pelvic examination was again made with no change in the findings. Further examination was advised, but the patient was apprehensive.

sive and wanted to defer this. She says that she had no further bleeding until early January 1961, when she had bleeding for several days. She returned to her physician and this time agreed to go to the hospital clinic.

Diagnosis: Carcinoma of the cervix, international classification, stage I.

Treatment: Radiation therapy.

CHAIRMAN: We all see this kind of thing. Those of you who are in general practice see it more than we do. It is a difficult problem.

COMMITTEE MEMBER: I think this is patient delay all the way. The patient was advised to go to the hospital clinic or to a specialist but she did not go.

PHYSICIAN: Shouldn't the doctor have taken a Papanicolaou smear?

COMMITTEE MEMBER: He reports that the cervix appeared to be "eroded." He probably thought that she had something there that should be biopsied and therefore thought it best for her to go to a hospital or to a specialist.

COMMITTEE MEMBER: If the patient is given the right advice and does not follow it, I think the responsibility for delay is the patient's.

PHYSICIAN: This patient had postmenopausal bleeding, and an "erosion" was visible on the cervix. I think the doctor should have insisted on getting a diagnosis or discharging the patient.

PHYSICIAN: You can advise patients, but I don't think you can make them follow advice.

COMMITTEE MEMBER: This patient did not make only one visit to the physician; she was seen three times within a month. It would have been a simple matter to take a Papanicolaou smear. This would almost certainly have been positive, and the patient might have been more easily persuaded that further examination was necessary.

CHAIRMAN: Yes, I think that is a good point.

It is a difficult problem, but certainly when carcinoma is suspected, everything possible must be done to establish the diagnosis as early as possible.

The patient was 54 years old, gravida 0. She gave a history of amenorrhea January to April 1960, followed by periods at irregular intervals to January 1961. She says that beginning in June or July of 1960, she had considerable pain in the right leg and back which was thought to be arthritis. She later developed considerable swelling in this leg. In September she had an episode of "pleurisy" on the right. For several months she had rather vague abdominal discomfort and gradual enlargement of the abdomen. She was under the care of her physician intermittently for these several complaints. She was referred to a gynecologist in January, 1961. At this time the abdomen was said to be about the size of a six-months pregnancy. She was admitted to the hospital and on January 29 had a total abdominal hysterectomy and a bilateral salpingo-oophorectomy.

Diagnosis: Papillary serous cystadenocarcinoma, right ovary, with extensive metastases.

CHAIRMAN: This is rather typical of the cases of carcinoma of the ovary which we have reviewed in this study. It is difficult to diagnose. The patient's complaints are often vague, and the abdomen is not necessarily the center of attention. There may be pain in the extremities or other difficulties.

PHYSICIAN: There is complaint of gradual abdominal enlargement in this case. Was a pelvic examination made at any time?

CHAIRMAN: According to our information, a pelvic examination was not made until the patient was referred to a gynecologist.

PHYSICIAN: I think this is physician delay.

COMMITTEE MEMBER: If this had been done, the disease would almost certainly have been diagnosed earlier.

CHAIRMAN: Would you agree that this case should be classified physician delay.

PYHICIAN: We are looking at these cases in retrospect, which makes it a lot easier to know what should have been done along the way. This patient had multiple complaints; so many complaints that she was probably a real problem to her doctor, and he could not see a tree for the forest.

PYHICIAN: I think this patient should have had a pelvic examination. If the physician did not want to do a pelvic, he should have referred her to someone who would. She had a good many symptoms and she had good reason to have symptoms; the disease was there. If a pelvic had

been done, it should have been found long before it was.

PYHICIAN: I know a good many doctors who would not do a pelvic for these symptoms.

PYHICIAN: I examine every patient over the age of 35. I think a pelvic should be a routine examination with patients over 35, and they should be educated as to the importance of this.

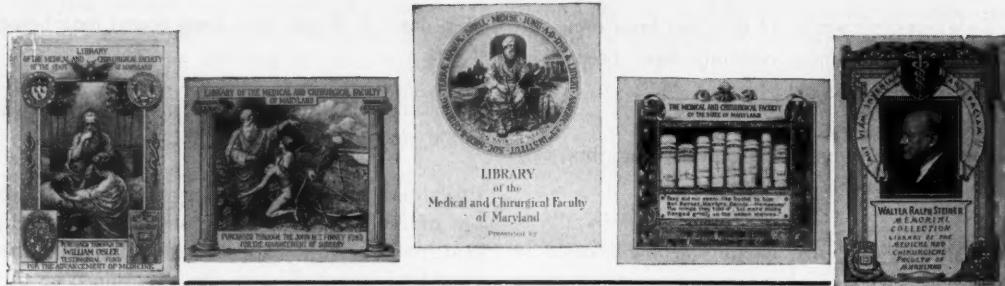
COMMITTEE MEMBER: Someone might get the impression from the history in this case that ovarian tumors cause irregular bleeding. I think we should point out that this is not always true. Neither ovarian cysts nor carcinoma of the ovary often causes abnormal bleeding.

CHAIRMAN: One of the most difficult things about this disease is that the symptoms are vague. The patients are often not able to give any specific complaint. This is a good reason for making a routine pelvic part of an examination.

RESOLUTIONS

Medical and Chirurgical Faculty

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Library

George L. Yashur, *Librarian*

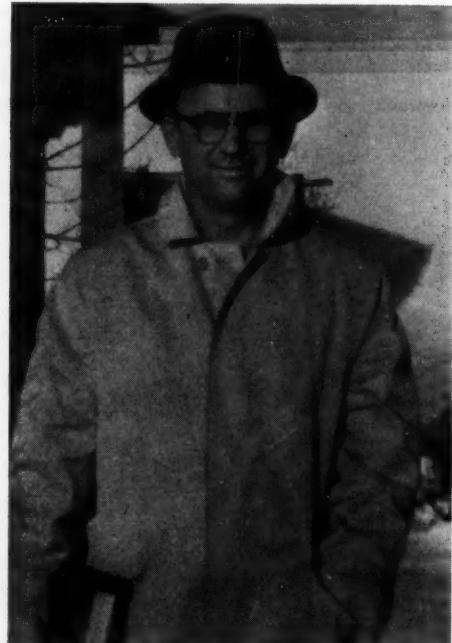
"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *Ibn Tibbon*

AFTER twenty-seven years as librarian for the Medical and Chirurgical Faculty, Miss Louise D. C. King has retired. Succeeding her is George L. Yashur, who left a post as librarian at the Naval Supply Depot, Mechanicsburg, Pennsylvania, to return to the medical library field.

He had previously been head librarian for five years at the Medical-Biological Library of the St. Louis University School of Medicine. As the only professional librarian on the staff, he was responsible for all professional library services, as well as extensive bibliographies and abstracts in scientific literature. Earlier stepping stones to this career included positions as medical literature cataloguer at the College of Physicians and Surgeons, Columbia University, and reference bibliographer at the Library of Congress, Technical Information Agency.

Mr. Yashur graduated magna cum laude in 1949 from Seton Hall University, South Orange, New Jersey. He earned a Master of Library Science degree in 1950 from the Catholic University, in Washington, D. C. Supplementing his

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education in medical library work, he took a reference and bibliography course in medical literature at the National Library of Medicine.

During World War II, he was a pharmacist mate in the United States Navy.

He is fluent in or familiar with nine languages: Latin, Greek, German, Slovak, Polish, Russian, French, Italian, and Spanish.



Maryland SOCIETY OF PATHOLOGISTS INC.

EDWARD C. McGARRY, M.D., President MANNING W. ALDEN, M.D., Secretary
Annapolis, Md.



PATHOLOGY AND THE PRACTICE OF MEDICINE

IT MAY SEEM STRANGE to put in juxtaposition two concepts which are commonplace to all physicians. It is perhaps this very familiarity with the terms that fogs our perception of the growing importance of their relationship.

Somehow the expression "practicing medicine" has developed for most people, even for many physicians, the connotation of treating patients. Partly because of this and partly because many of his daily problems are different from those of his clinical colleagues, the pathologist and his professional activities are not always fully recognized as the practice of medicine. The direction of a clinical laboratory is the practice of medicine. The person responsible for the laboratory must be a doctor of medicine whose specialty training is in pathology and whose medical educational background is the same as that of his clinical colleagues. The clinical pathologist is convinced that every procedure performed in his laboratory must be done with the same care that the clinician takes with the diagnosis and treatment of patients.

Pathologists have been struggling many years for full recognition as practitioners of medicine. Today when the professional freedom of all physicians is being encroached upon by third parties; i.e., government, insurance carriers, and hospitals, a positive step against such encroachment would be for fellow physicians to acknowledge the practice of pathology as the practice of medicine with all its rights and responsibilities.

Each advance in medicine makes laboratory studies more essential for the diagnosis and treatment of patients. Despite the expansion of hospital and non-hospital laboratories, there continues to be insufficient laboratory facilities to meet the needs of clinicians. These unfilled needs have led to the rise of many laboratories operated by non-medical persons. Unfortunately, all too often the profit motive looms larger in this development than service to the patient, with consequent dangers to patient care.

There have been several types of reaction to the obvious deficiencies of many of these laboratories. One has been for the state to license medical laboratories. Warnings concerning the development and utilization by physicians of non-professional, second-rate laboratories have been repeatedly brought to the attention of the profession. These efforts have been largely ignored by physicians in general. Whether this lack of response resulted from indifference to problems which were poorly understood to begin with is not important. It is important, however, for the profession to recognize that the practice of laboratory medicine must not be lost to third party control, a danger for all physicians.

STATE OF MARYLAND

DEPARTMENT OF MENTAL HYGIENE

Isadore Tuerk, M.D., Commissioner

Kurt Gorwitz, Statistics Director

Model Reporting Area for Mental Hospital Statistics

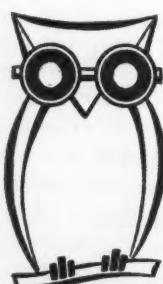
THE MARYLAND DEPARTMENT of Mental Hygiene has been officially informed that its Statistics Section was elected to the Model Reporting Area for Mental Hospital Statistics by unanimous vote of the twenty-two member states.

Admission to the Model Reporting Area is one of the major achievements of a long-range program inaugurated two and a half years ago for providing Maryland with a modern and efficient mental health statistical program. Several of the special projects included in this long range plan have been reported previously.

Maryland will be the twenty-third member state in the Model Reporting Area and the ninth among the sixteen states in the Southern Region. Mem-

bership is based on an ability to meet the qualitative and quantitative standards established by the organization.

The Maryland Mental Hygiene Department looks forward to participating actively in this organization. Membership offers many advantages to us. It will enable us for the first time to compare accurately our patient program with similar services in other progressive states. It will also be possible for the Department to participate in special research projects which could not be done in this state alone. We hope that the knowledge gained from these projects will produce further improvement in the care and treatment of Maryland's mentally ill.



**YOU'RE WISE IF YOU PLAN NOW
TO ATTEND THE**

OCEAN CITY MEETING

(Semiannual Meeting of the Medical and Chirurgical Faculty
of the State of Maryland)

FRIDAY, SEPTEMBER 15
COMMANDER HOTEL



The

Heart Page

Luis F. Gonzalez, M.D.—Editor

THE HEART ASSOCIATION OF MARYLAND

INDICATIONS FOR RIGHT HEART CATHETERIZATION

Donald H. Dembo, M.D.

SURGICAL ADVANCES have imposed additional responsibilities on the physician, for he must now consider the possible application of surgical, as well as medical, treatment in cardiac diseases. He must be able to diagnose lesions by conventional methods and to recognize the indications for more complex diagnostic procedures, including cardiac catheterization.

Right heart, left heart, or combined catheterization is performed in order to obtain physiologic data which can be correlated with clinical observations in establishing specific cardiac diagnoses and evaluating functional severity. The procedures utilized depend on the clinical impression.

Noncyanotic congenital heart disease is particularly suited to right heart catheterization. The catheter is advanced through a peripheral vein into the right atrium, right ventricle, and pulmonary artery, where oxygen saturations and pressures are obtained. A step up in oxygen saturation or the demonstration of pressure gradients provides diagnostic information regarding intracardiac shunts or valvular deformities. Specific dye substances and radioactive materials, such as Krypton⁸⁵, can provide additional information, and selective angiography (from specific chambers) permits direct visualization of congenital and acquired defects.

Acquired heart disease such as rheumatic heart disease is often better studied by left heart catheterization or combined techniques, since the valvular lesions are usually mitral or aortic. Nevertheless, right heart catheterization can provide such important data as pulmonary artery pressures at rest and after exercise. In addition, the pressure obtained with the catheter wedged dis-

tally in a pulmonary artery reflects left atrial pressure.

Cardiac catheterization is useful in differentiating functional disorders or innocent murmurs from organic disease. A major indication is the need to establish an accurate diagnosis in anticipation of surgical correction. Routine techniques of evaluation may be adequate to establish the diagnosis of most congenital and acquired lesions; however, complete assessment of these defects is often necessary to evaluate severity and determine prognosis. For example, elevated pulmonary artery pressure with bidirectional or reduced left to right shunts alter the indications and prognosis for surgery in interventricular septal defects.

Similarly, when it is felt that operative intervention can be postponed without prognostic risk, catheterization may also be postponed. Indications differ in the pediatric patient and in the adult. A noncyanotic child with congenital heart disease who is troubled with frequent respiratory infections or dyspnea or who demonstrates poor growth and development is a candidate for catheterization. On the other hand, it had been the common practice to manage expectantly an infant with a diagnostic heart problem who thrived and did well. Often this conservative approach permitted resolution of the problem by clinical observation, thus avoiding the added risk of analgesia or anesthesia and the difficulty in catheterizing the small patient. In some clinics, however, infants are being catheterized earlier in order to obtain exact diagnoses to permit more definitive management. In the child or adult, cardiac catheterization is usually justified to resolve less pressing problems.

Another major indication for right heart cathe-

terization is the assessment of surgery. Postoperative clinical evaluation may be misleading at times. The catheterization procedure may provide information about residual defects or serve as a guide for evaluating operative techniques.

Catheterization is not without some risk. Transient cardiac arrhythmias are common, but are rarely serious. Venous thrombosis, phlebitis, and pyrogenic reactions are uncommon. An incidence of less than .004 per cent has been reported for

rupture of the coronary sinus, air embolism, or knotting of the catheter within the heart. The hazards of the procedure are indeed minimal in contrast to the benefit obtained.

Right heart catheterization, like electrocardiography, is a diagnostic tool, an ancillary aid to the clinical impression. In conjunction with complete clinical evaluation, cardiac catheterization has contributed to our understanding of heart disease and the planning of effective remedial measures.

ETHICS CORNER

COMPULSORY ASSESSMENTS AND COMPULSORY AUDITS BY HOSPITALS

We have had numerous inquiries as to the right of a hospital or medical staff to levy compulsory assessments on its medical staff members or to demand an audit of a physician's personal financial records.

The appropriate excerpt from Reports and Opinions of the AMA Judicial Council regarding Section 7 of the Principles of Medical Ethics reads as follows:

"Neither the hospital management nor the medical staff has the privilege or the right to make compulsory assessments of members of the medical staff for building funds or to demand an audit of staff members' personal financial records as a requisite for staff appointment." (Adopted by House of Delegates June, 1960, meeting.)



Baltimore Area Council on Alcoholism

(Successor to Maryland Society on Alcoholism)

MARYLAND COMMISSION ON ALCOHOLISM 1961

BY AN ACT OF the General Assembly, the Maryland Commission on Alcoholism was created for the year beginning July 1, 1960, and recently extended for an additional year. The commission was formed to investigate the problem of alcoholism within the state and to consider (1) the present statutes, practices, and procedures for both voluntary and involuntary committal of alcoholics and (2) the present methods of and facilities for the treatment of acute and chronic alcoholics.

On February 10, 1961, the commission submitted its first report to the Governor. Under the chairmanship of Lewis P. Gundry, M.D., the commission succeeded in establishing an office and engaging the consultant and working staff of Harrison M. Trice, Ph.D., Howard M. Bubert, Jr., LL.B., and Lillian M. Snyder, M.S.S., by September 1, 1960.

The commission agreed upon a definition of alcoholism. *If entirely or in part because of the excessive use of alcohol a person behaves in a manner which deviates from the normal pattern of behavior, and if whenever alcohol is used these deviations consistently recur, then such a person is an alcoholic and is suffering from alcoholism.*

Using the Jellinek Formula, the commission estimated that there were 76,700 alcoholics in the state in 1959. This report considered the relationship of the alcoholic to many state agencies, such as the Police Department, penal institutions, and Department of Motor Vehicles. It was concluded that, although the alcoholics encountered in these areas of government are but a minority of the total (up to 10 per cent), they constitute one of the most pressing problems and inhibit the proper functioning of these agencies. Generally such agencies have no specific facilities for the care of the alcoholic. Until this pressing problem is attacked, it will be impossible to combat successfully the larger group of hidden alcoholics, who are the most responsive to treatment.

A list was made of the psychiatric and medical agencies available to combat alcoholism, and surveys of their makeup, goals, and effectiveness were initiated. The Department of Mental Hygiene has complete power and supervision over all matters relating to the custody, care, and treatment of the insane; in Maryland, existing law *pertaining to the insane* is employed for alcoholics. Crownsville, Eastern Shore, Springfield, and Spring Grove are the state hospitals currently used for care and treatment of alcoholics. The programs at two of these hospitals will be described in future articles in this series. Many alcoholics remain in the state hospital only long enough to "dry out" and then seek release. The high readmission rate for alcoholics at the various hospitals (46 per cent to 130 per cent) seems to be reducible by participation in an intensive program. It has been reduced to less than half at Spring Grove. In addition to the Perry Point Veterans Administration Hospital and the University of Maryland Psychiatric Institute, there are seventeen private psychiatric institutions, ten of which treat alcoholics. Although forty-eight outpatient clinics serve alcoholics, only thirty-two of these saw patients during 1958-1959. The relative voids in formal teaching of alcoholism to nursing and medical students, in programs in industry, and in acceptance of alcoholics by nursing homes were noted.

The conclusions of the report are as follows:

- (1) There is no uniformity in the definition, identification, or treatment goals among agencies and institutions.
- (2) There is no followup of even elaborate treatment to evaluate effectiveness.
- (3) There is no coordination among groups handling alcoholics.
- (4) Because of this, discharge planning and continuity into the community is generally non-existent.
- (5) Many professional staff members have lit-

tle or no training or experience in dealing with alcoholic patients.

- (6) Little is done to treat alcoholism in the alcoholic tuberculosis patient.
- (7) Constant readmissions are overtaxing the services of the state mental hospitals.

Upon the basis of the study, the life of the commission was extended for an additional year with specific recommendations that (a) further study of the extent of chronic police case inebriates be made, (b) planning for a statewide facility for unresponsive chronic police court inebriates, and counseling service for early or responsive alcoholics coming before magistrates' courts be

started, (c) the intensive alcoholism treatment program at Spring Grove State Hospital be increased and extended to the other state hospitals and followup evaluation of the results of these treatments obtained.

The commission is gathering much useful data on the above topics and making them available to interested agencies. It is commendable that this commission has chosen the gathering of factual data on many facets of alcoholism as the initial goal. Once the problem is defined and the effective contribution of each type of treatment determined, it will become possible to organize treatment centers.

Frank L. Iber, M.D.



These books are available
in our Library

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, ed. 2, George A. Ulett, M.D., and D. Wells Goodrich, M.D. St. Louis: The C. V. Mosby Company, 1960.

This handbook is a brief, ready reference in psychiatry. It is compact enough to fit in the side pocket of the clinic coat. Theory is kept to a minimum. The organization of the book is upon three general areas: history and diagnostic procedures, clinical syndromes, and therapeutic measures. The section on therapy has been considerably revised in accordance with advances in psychiatric treatment.

ESSENTIAL PATHOLOGY, Roger D. Baker, M.D. Baltimore: The Williams & Wilkins Company, 1961.

This book is a portrayal of disease, directed to the student who is preparing himself for practice or research. The subject matter has been selected in proportion to the frequency and severity of disease. In the interest of brevity, normal structure and function are omitted.

CLINICAL DISTURBANCES OF RENAL FUNCTION, Abraham G. White, M.D. Philadelphia: W. B. Saunders Company, 1961.

When the practicing physician is confronted with a patient whose kidneys are not functioning normally, three problems are paramount: is the patient suffering from renal dysfunction, what is it, and what should be done? This book is meant to help the doctor attain insight into what the patient is suffering from and what to do for him. Each chapter has a selected list of bibliographic references.

A MANUAL OF CUTANEOUS MEDICINE, Donald M. Pillsbury, M.D., Walter B. Shelley, M.D., and Albert M. Kligman, M.D. Philadelphia: W. B. Saunders Company, 1961.

The objectives of this volume are: 1) to summarize the chief useful facts regarding the diagnosis, prevention and cure of the diseases affecting the skin which are commonly encountered in daily practice; 2) to summarize those principles of physiology, chemistry, and anatomy which are most useful in understanding the genesis of skin disease; 3) to emphasize those changes in the skin which may be representative of systemic disease; 4) to assess the various methods of treating diseases of the skin; 5) to indicate which diseases may ordinarily be managed by the general practitioner and which may require a specialist. Terminology is kept as simple as possible, and graphic presentation is used wherever it would contribute to brevity and clarity of the information.

MANAGEMENT OF HYPERTENSIVE DISEASES, Joseph C. Edwards, M.D. St. Louis: The C. V. Mosby Company, 1960.

Paul Dudley White, M.D., in the foreword to this book, has written: "This book by Dr. Edwards presents clearly and succinctly the present status of the problem of hypertension and its treatment. Important details of the use of the potent drugs alone and in combinations are included. As yet we are in the very midst of a rapid evolution of our knowledge not only of the treatment of hypertension but of that disease process itself. Without doubt new editions will be needed in the not far distant future to keep up with these advances."



MARYLAND TUBERCULOSIS ASSOCIATION

Christmas Seal Agency for State of Maryland

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

SURGERY IN MARYLAND STATE TUBERCULOSIS HOSPITALS

A review of our experience with surgery in the treatment of tuberculosis at Mount Wilson State Hospital is reported. Six hundred and thirty-four operations have been performed, 530 of which were resections. The incidence of bronchopleural fistula in the resections was 3.4 per cent, and the overall mortality, 1.4 per cent.

THE PRESENT PROGRAM for surgical treatment of pulmonary tuberculosis in the State Tuberculosis Hospitals was initiated in September 1957 at Mount Wilson State Hospital, in cooperation with the Thoracic Surgery Division of University Hospital and the University of Maryland School of Medicine. We will briefly review the concepts and the early results of this treatment.

All patients are evaluated at a combined medical surgical conference. These patients have received medical therapy consisting of supportive care, bed rest, and chemotherapy for tuberculosis, usually for four months or longer, depending upon the extent of disease and its response to therapy.

John E. Miller, M.D.¹

Eugene Linberg, M.D.²

Safuh Attar, M.D.³

Elmer P. Sauer, M.D.⁴

Exception is made when associated malignancy is suspected.

The pre-surgical evaluation comprises review of all previous x-rays of the patient, complete medical history, bacteriologic response to drug treatment as evaluated by sputum and gastric cultures for tubercle bacilli, and the general medical status of the patient. When surgical treatment seems indicated, ancillary studies are requested in order to evaluate more properly the extent and type of surgery.

We agree with most other physicians that resection is the modern concept of surgical treatment of tuberculosis. To date six hundred and thirty-four surgical procedures have been performed: twenty-nine (5.35 per cent) in patients with minimal tuberculosis, two hundred and sixty-four (48.70 per cent) in moderately advanced, and two hundred and forty-nine (45.95 per cent) in far advanced cases. There were fifty-eight (10.94 per cent) pneumonectomies, one hundred and ninety-six (37 per cent) lobectomies, fifty-six (10.56 per cent) lobectomies and segmental resections, two hundred and seventeen (40.94 per cent) segmental resections and three (0.56 per cent) wedge resections. Seven patients (1.3 per cent) have been treated with primary collapse procedures. In most instances when a thoracoplasty is performed, it is done as a preliminary to resectional surgery. There were thirty-two preresectional thoracoplasties and three concomitant thoracoplasties done simultaneously with the resection to obliterate space unfilled by the remaining lung tissue.

Bronchoscopy is performed in all patients before operation. Routine laminograms are obtained prior to the medical surgical consideration. Bronchography is performed on most patients, so that together with bronchoscopy, we can thoroughly

¹ Chief, Thoracic Surgery, Mt. Wilson State Hospital.

² Assistant Professor of Surgery, University of Maryland School of Medicine.

³ Instructor in Surgery, University of Maryland School of Medicine.

⁴ Medical Director, Tuberculosis Hospitals, State Department of Health.

evaluate the bronchial component of the disease and thereby make the excision of diseased pulmonary tissue more definitive and conservative of functioning lung. Gross spirometry is performed on all patients. Bronchspirometry to determine differential function is utilized in patients with bilateral disease and in those in whom pneumonectomy is being considered. Occasionally more precise evaluation of cardiopulmonary function is necessary through cardiac catheterization to determine pulmonary artery pressure and arterial oxygen saturation as affected by exercise.

The following constitute our indications for surgery:

1. Residual cavity, 383 (71.50 per cent)
2. Significant residual disease, 44 (8.22 per cent)
3. Destroyed lobe or lung, 69 (12.90 per cent)
4. Bronchiectasis with or without positive sputum but symptomatic 29 (3.72 per cent)
5. Collapse failure, 6 (1.1 per cent)
6. Bronchopleural fistula, 13 (2.42 per cent)
7. Suspected malignancy, 2

Our concept of adequate surgical treatment is the removal of diseased lung tissue which we consider unlikely to remain under control after the patient has returned to his normal activities. This, of course, requires individual application of the above indications, modified by the socioeconomic status of the patient. The principle of preserving functioning lung tissue while, at the same time, excising all diseased lung accounts for the high rate of segmental resections (40.94 per cent) in our series.

Postoperative management is important. Drug therapy is continued. Bed rest is temporarily in-

terrupted in the immediate postsurgical period, then is resumed and continued routinely for three months for the usual patient in whom the significant disease is thought eliminated; otherwise, it is variably extended. After this, gradual resumption of physical activity is encouraged, thereby preparing the patient for normal activity upon discharge, which is usually five months after operation with a minimum of one year total drug therapy.

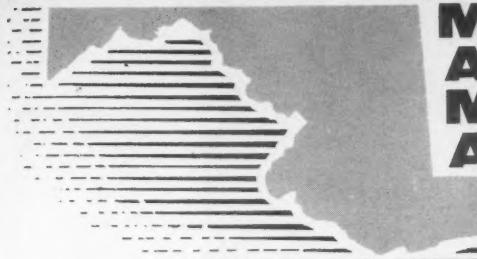
The most serious complication after pulmonary resection is bronchopleural fistula. Careful evaluation of each patient, pre-resectional thoracoplasty, and bacteriologic control account for the low incidence in our series. There were eighteen bronchopleural fistulae in five hundred and thirty lung resections, an incidence of 3.4 per cent, which compares favorably with the series of Bickford, Edwards, and co-workers (5 per cent), Chamberlain and Klopstock (5.3 per cent), and Barrett and Tuttle (6.2 per cent). These bronchopleural fistulae were treated by thoracoplasty in sixteen patients, four of whom required an additional muscle flap procedure. The other complications include empyema (eight), residual space that required tube reinsertion (sixty-five), atelectasis (thirty-two), and prolonged leak (twenty-six).

The overall mortality was 1.4 per cent; whereas the resectional mortality was 1.7 per cent, which compares favorably with Bickford's series (1.71 per cent), Gale and Curreri (3.1 per cent), and Barrett et al (4.8 per cent). The causes of death were postoperative empyema with hemorrhage, (one), postoperative bleeding (two), cardiorespiratory failure (two), overdose of curare (one), atelectasis (one), delirium tremens and sepsis (one).

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

THE MARYLAND ASSOCIATION, a chapter of the American Association of Medical Assistants, was founded in November, 1960. A charter has been granted and will be presented to the Maryland Chapter at the annual convention of the American Association of Medical Assistants in Reno, Nevada, to be held October 12 through 15, 1961.

The American Association of Medical Assistants was formed in 1956 by representatives of thirteen state societies and many local groups. Its first annual meeting was held in San Francisco in October, 1957, following approval by the House of Delegates of the American Medical Association, in November, 1956, of a resolution commending the objectives of the American Association of Medical Assistants. This is a unique honor, since it is the only medical assistants organization approved by the American Medical Association. The American Association of Medical Assistants has executive offices in Chicago, across the street from the American Medical Association headquarters at 510 North Dearborn Street.

Maryland presently has two local chapters of medical assistants: the Allegany-Garrett County Medical Assistants Association and the Baltimore Association of Medical Assistants. Several county groups are planning to form chapters in the coming year.

Membership in a medical assistants society is open to receptionists, secretaries, bookkeepers, nurses, technicians, and assistants employed in the offices of doctors of medicine or accredited hospitals. A physician employer of such a medical assistant must be a member of his local and state medical society.

The Objectives of the Maryland Association of Medical Assistants are:

- (a) To inspire its members to render honest, loyal, and more efficient service to the profession and to the public which they serve.
- (b) To strive at all times to cooperate with the

medical profession in improving public relations.

- (c) To render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation among its societies.
- (d) To encourage and assist all unorganized medical assistants in forming local societies.
- (e) This Association is hereby declared to be non-profit. It is not nor shall it ever become a trade union or collective bargaining agency.

The officers of the Maryland Association of Medical Assistants are:

Dorothy Hartel, *president*
Desma Usher, *vice president*
Virginia Keller, *secretary*
T. Margaret Krize, *treasurer*

Advisors
Russell S. Fisher, M.D.
Charles S. Petty, M.D.

The officers of the Allegany-Garrett County Medical Assistants Association are:

Virginia Keller, *president*
Mary Melligon, *vice president*
Barbara Largent, *secretary*
Carol O'Donnell, *treasurer*

Advisors
Robert Feddis, M.D.
Leslie R. Miles, M.D.
David Miller, M.D.

The officers of the Baltimore Association of Medical Assistants are:

Dorothy E. Holman, *president*
Lillian Burford, *vice president*
Jean D. Roberson, *secretary*
Dorothy Hartel, *treasurer*

Advisors
Russell S. Fisher, M.D.
Charles F. O'Donnell, M.D.

Dorothy Hartel



Woman's Auxiliary

Medical and Chirurgical Faculty

MRS. WILLIAM S. STONE, Auxiliary Editor



JULY, 1961

THE PAST PRESIDENTS of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland formed a Past Presidents Club. The meeting took place at the traditional breakfast, April 27, in the Belvedere Hotel. The following were present: Mrs. Thomas A. Christensen, Mrs. George H. Yeager, Mrs. Charles H. Williams, Mrs. John G. Ball, Mrs. Albert E. Goldstein, Mrs. Homer U. Todd, Mrs. David S. Clayman, Mrs. E. Roderick Shipley, Mrs. D. Delmas Caples, Mrs. William S. Stone, and Mrs. Norman E. Oliver.

* * * *

MARYLAND WAS represented at the annual meeting of the Woman's Auxiliary to the American Medical Association by Mrs. Norman E. Oliver, presidential delegate, Mrs. Robert P. Conrad, chairman of delegates, and Mrs. Raymond V. Rangle and Mrs. William S. Stone as delegates. Mrs. Albert E. Goldstein was chairman of the Resolutions Committee for this important national Convention, held in the Roosevelt Hotel in New York City.

* * * *
IF YOU DID NOT attend our own Annual Meeting in April at the Belvedere Hotel you missed:

Learning of the excellent work being done in our county auxiliaries.

Meeting Mrs. William G. Mackersie, of Detroit, Michigan, president of the Woman's Auxiliary to the AMA and Mrs. Roy A. Douglass, of Huntingdon, Tennessee, president-elect of the Woman's Auxiliary to the Southern Medical Association.

Seeing A beautiful fashion show with our own members, Mrs. Arnold Field, Mrs. Arnold Vance, Mrs. J. Theodore Stacy, Mrs. John M. Dennis, Mrs. Richard Sindler, Mrs. Albert E. Goldstein, Mrs. Sullins G. Sullivan, and Mrs. Walter M. Hammett as models.

Sailing aboard the "Port Welcome" for a two-hour tour of the Baltimore Harbor.

Student Aid Committee

of The Woman's Auxiliary to the Baltimore City Medical Society

DURING A FAIRLY active year, a number of inquiries and requests for aid were handled by the Student Aid Committee, composed of Mrs. Conrad Acton, Mrs. E. E. Cook, Mrs. Albert E. Goldstein, Mrs. Robert Reiter, Mrs. Vernon Smith, Mrs. S. G. Sullivan, Mrs. Leonard Warres, and Mrs. Peter Ball, chairman.

Two loans of \$500 each went to students at the University of Maryland School of Medicine, and a senior in the Johns Hopkins Medical School is now being considered for a \$600 loan.

For the second year, our Woman's Auxiliary scholarship of \$250 has been awarded to both a student of the University of Maryland and one of the Johns Hopkins medical schools.

Of the \$4700 granted in loans since 1956, when our first loan was given, we have, an aggregate of \$555 has been repaid. At present, there are no overdue payments. We enjoy seeing this "revolving fund" put back into constructive circulation.

Ann S. Ball, chairman



New officers of the State Auxiliary. Seated, left to right: Mrs. Wallace H. Sadowsky, recording secretary; Mrs. Robert P. Conrad, president elect; Mrs. Norman Oliver, president. Standing: Mrs. Roy K. Skipton, fourth vice president; Mrs. John E. Baybutt, third vice president; Mrs. Archie R. Cohen, second vice president; Mrs. Raymond V. Rangle, first vice president; Mrs. Emil G. Bauersfeld, treasurer. Not shown: Mrs. George R. Spence, corresponding secretary.



Mrs. William S. Stone, retiring as president, hands the gavel to her successor, Mrs. Norman R. Oliver.

Past Presidents Breakfast (left to right): Mrs. Albert Goldstein, Mrs. D. Delmas Coples (with back to camera), Mrs. George H. Yeager, Mrs. Homer U. Todd, Mrs. David Clayman, Mrs. William S. Stone, Mrs. Thomas Christensen, Mrs. Norman Oliver, Mrs. John Ball, Mrs. Charles H. Williams. Also present, but behind the camera, was Mrs. E. Roderick Shipley.



Honored guests were Mrs. Roy A. Douglass and Mrs. William R. Mackersie.



JULY, 1961



Mrs. Albert E. Goldstein (above) and Mrs. Sullins G. Sullivan (below) modeling at fashion show.



Introducing Our County Presidents



Mrs. Robert W. Garis, President
Woman's Auxiliary to the
Baltimore City Medical Society

KITTY GARIS, IN PAST YEARS, has served as recording and corresponding secretary of the auxiliary. During her membership, she has worked with various committees whose output reflected her able leadership. An alumnus of Goucher College and Johns Hopkins University, she is an active worker in civic and charitable organizations. She has served in a presidential capacity in the Innerwheel of Baltimore Rotary and the Junior Board of Keswick Home. She served a term on the Board of Governors of the Woman's Club of Roland Park and held committee chairmanships in the Empty Stocking Club and other organizations. In addition, she has participated in hospital auxiliary work and church groups. Dr. and Mrs. Garis make their home in the Ambassador Apartments.

The Annual Meeting of the West Virginia Heart Association will be held at the West Virginia University Medical Center, Morgantown, West Virginia, on Friday, September 15, 1961, 9 A.M. to 5 P.M. The all-day program for physicians will be presented by the teaching staff of the West Virginia University Medical Center. Details of the program will be announced later.